# New York State Journal of Medicine

Published by the
MEDICAL SOCIETY
of the STATE of NEW YORK



Volume 47

Part 2

JULY 1-DECEMBER 15, 1947

(Pages 1439-2748)

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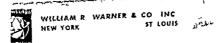
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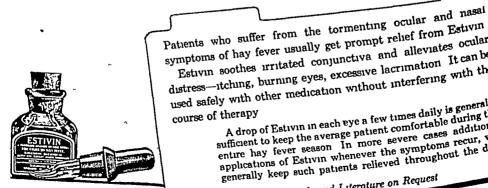
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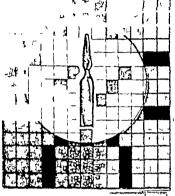
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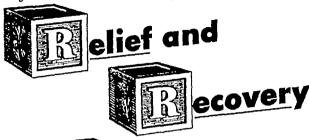
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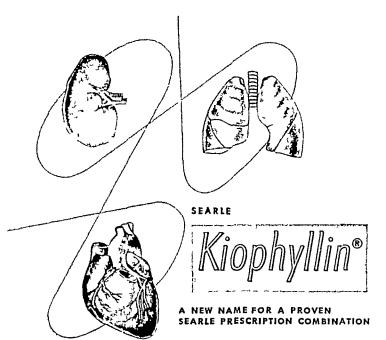
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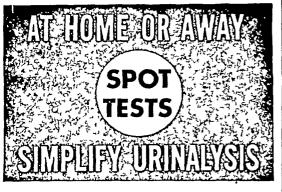
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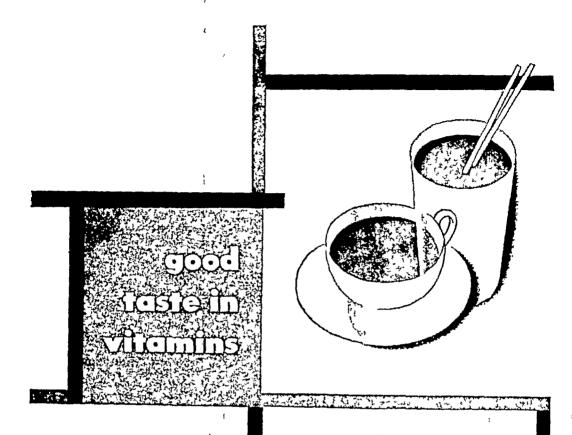
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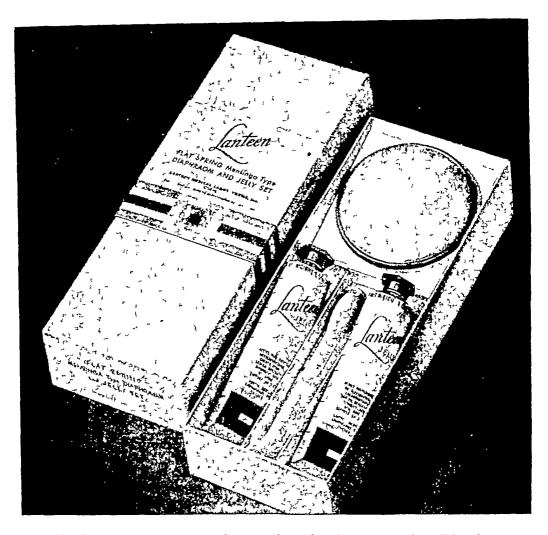
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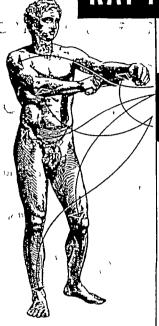
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It is the fight against ignorance, sloth, superstition.

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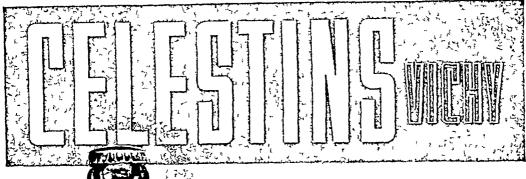
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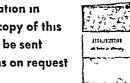


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**VOLUME 47** 

IULY 1, 1947

NUMBER 13

# **Editorials**

#### A Wider Horizon for the General Practitioner

One of the laments most frequently voiced by the public and echood, when it seems judicious to do so, by the medical profession, is What is to become of the general practitioner? Well, what is?

We are all familiar with the complaints about the undue rise of specialists about the lengths to which specialism has been allowed to progress—or, should we say, to which the practice of medicine has been allowed to alump?

If parts of this editorial seem faintly personal we are sorry, but we do not apologize, because personal experience, honestly related, is the only basis for true history from which pertinent conclusions may be drawn

In the first place, what is a hospital? The general practitioner would probably reply that it was an institution he couldn't get his patients into. We think his reply would be fairly correct, and propose to examine the reasons why this is so

Thirty five years ago the hospital was an institution with a big name staffed by the professors in our medical schools, in which internships under professors of the greatest reputation were caparly sought by such

medical students as could afford to take them Many of us could not

For the fortunate ones who could, the hospital offered ample clinical material where the art of caring for the aick was taught by the most experienced teachers Neither the instructors nor the pupils were Both basked in an atmosphere of altrusm that was wonderful-if you could afford it At the end of two years interns would emerge from the hospital with a considerable reputation, they had succeeded not only in getting into the institution but in getting out of it Many of them then coasted into success upon the cont-tails of their preceptors They were known to an awestruck circle of contemporaries, not only as graduates of a certain hospital, but also as "the best surgical assistant Dr Blank had had in years, Thus they frequently were introduced into fashionable practice and were so well rewarded financially that when their predecessors died they were able to step into their shoes. It was an excellent arrangement-for a few And, let us emphasize again for the few who could afford it

In the meantime, what happened to those

who could not? They went into general Their patients were not as a rule anxious to go to hospitals and preferred to be Under such conditions cared for at home the general practitioner did fairly well When a patient became obviously desperately ill, he would be sent to the hospital, there to be operated on by a brilliant classmate who had a hospital appointment Sometimes the brilliant classmate would be so touched by the shabby appearance of his less fortunate brother, who had referred the case to him, that he would share with him a portion of the substantial fee received from the patient Sometimes the less fortunate brother would spread the tale of the charitably-minded surgeon and other general practitioners would refer cases to him in the hope of encountering similar financial justice Thus arose the hemous practice now slightingly referred to as "fee-splitting" We do think it a hemous practice, because it results in patients being referred not to the best, but to the most, shall we say, generous sur-But we think it only fair to point out the genesis of the custom

1480

Then came the advent of the so-called "teaching hospitals," staffed by cloistered graduates who often never had engaged in the private practice of medicine. After their internships they had stayed on and on as residents, and after they had become sufficiently expert were frequently drafted by other institutions to become full-time professors of surgery or medicine. As scientists they are wonderful, but they have small comprehension of, or sympathy with, the problems of the general practitioner

And during this time, the public has become more and more hospital conscious. It wants to go to the hospital for the mildest stomach ache or sore throat. And with the spread of voluntary hospital insurance it can afford to do so.

Naturally the Blue Cross is anxious—for its own sake—that its clients patronize only the hospitals with the best staffs, in which a patient's stay is likely to be as brief as possible

Trustees of voluntary hospitals will tell you, with tears in their eyes, that, as trustees of charitable funds they must assure the spending of those funds for providing the best closed staffs possible. That sounds perfectly reasonable until you examine more closely and find the number of voluntary hospitals that allow themselves to be victimized by admitting compensation cases at rates less than the hospitals pay for the care of charity cases, cases for whose care they were originally founded 1 One would think that worldly-minded trustees would not allow themselves to be so bamboozled either by state compensation boards or by insurance companies Perhaps this is slightly beside the point, but it all goes to show how much farther and farther away the general practitioner is being pushed from the best facilities for, and contact with, the latest developments of scientific medicine

It is always easier to point out the defects of a system than it is to propose a remedy Some of our municipal hospitals are now staffed by members of the faculties of various universities, thus assuring the indigent the same degree of skillful care as that available to the rich who can afford to pay for it. That sounds well on the face of it, until we see that it is more and more narrowing the field to the general practitioner.

Suppose that the general practitioner were allowed to take his patient under voluntary hospital insurance to a municipal hospital Suppose that he were kept in charge of the patient from the beginning of his illness to We think there would be a conthe end siderable resurgence of that spirit which resolves to shoulder personal responsibility and see the patient through We are confident that there are still enough generous practitioners of medicine of the highest reputation who would be willing to help out their less fortunate colleagues in the matter of hospital appointments, with problems that to them seem insoluble

Suppose that under such a system the patient gets well? The father says "I never thought so much of Dr Smith I grew up with him and we live on the same block But when my kid got polio Smith was the only man I could get and he took care of him He took him to the Municipal Hospital He saw him every day He seemed to be doing all right, but Smith wasn't quite satisfied and called in Dr Jones He's the greatest authority on polio in these parts I don't

<sup>&</sup>lt;sup>1</sup> New England J Med 236 491 (March 27) 1947

know whether my kid's going to get completely well, but I do know that he's had the best of care and for money that I could afford to pay, and I've paid it No matter what happens in my family from now on, Smith's the man for me."

Dr Jones says "I never heard of that man Smith before But he called me in con sultation to see a case of polio he had in the hospital and he'd done everything all right. There was only one thing I could suggest and if I hadn't been there I guess he would have thought of it himself I didn't get much of a fee, but I got something, and under the old system I wouldn't have been paid a cent."

Dr Smith says "I got called in on a case of polio the other night—I wasn't sure at first what the trouble was, but the next day I got the kid into the Municipal Hospital—The

third day I called in Dr Jones You know he's got all hell of a reputation, but he wasn't a bit the kind of stuffed shirt I thought he'd

"His fee was only ten dollars, but he said that in the old days he would have had to see the kid anyway and wouldn't have been paid anything. It was all right with him. And he's ill right with me."

And so what have you? Three satisfied people A considerable cementing of the bonds that should be holding the medical profession together. Solidarity instead of disagreement. Sickness paid for without hardship.

It may sound like a dream, but it is one that the inclical profession hospital trus tees municipal governments and the general public would do well to make come true

### Commissioner Edward S Godfrey, Jr, Retires

The retirement of an outstanding, conscientious, efficient public health official ments the attention of the medical profession. The Medical Society of the State of New York has been most fortunate in having for nearly thirty years the advice and assistance of an eminent physician, Dr Edward S Godfrey, Jr, whose service in the New York State Department of Health came officially to an end when he retired May 1

His was a long and distinguished career Since 1936 the State Commissioner of Health, Dr Godfrey demonstrated an unusual ability in epidemiology research, and administration. In this brief acknowledgement of his affiliations with the State Soclety it is impossible to give a detailed account of his positions, activities interest, accomplishments, and honors

His personality, diplomacy and, particularly, his intense interest in doing things for the good of mankind will long be remembered.

He was adviser to the Council Committee of Public Health and Education of the Medical Society of the State of New York. The members of this Committee and its many subcommittees and the officers of the Society owe him a debt of gratitude for his wise counsel concerning a multitude of matters in the broad and ever-expanding field of public health

To 'Ted' Godfrey we express deep appreciation of his interest and assistance, with the hope that many years of activity and happiness await him

## Twenty Thousand Years of Medical Practice in New York State

There are about 400 physicians in the State of New York who have been in practice for fifty or more years. Their combined experience totals 20,000 years of active medical life, and embraces a period of time in

which the most rapid and widespread advances ever experienced took place, not only in medicine but in all the allied sciences, and in many of the arts, excepting the art of living. The mere extension of life itself

from an expectancy of thirty years not long ago to over sixty-five at the present time is not necessarily a cultural gain, nor a satisfaction of the "pursuit of happiness"

Of the 400 fifty-year practitioners of the State, 71 were in attendance at the Annual Meeting at Buffalo on the night of the banquet, May 7, 1947

Rarely is a medical gathering privileged to see in one place a group of men whose aggregate professional experience totals more than 3,550 years, men for the most part hale and hearty, taking life

as it comes, realistically, asking little, giving much. They have devoted more years, these 71 doctors, to the practice of medicine than has constituted the entire Christian era

The editors of the Journal very humbly add then congratulations to these iron men of medicine who have just received their certificates for fifty years of practice from the Medical Society of the State of New York

Their number, 71, constituted about 54 per cent of all the membership who registered at the meeting, 1,316 doctors, excepting guests

# The Journal and Directory Exhibit

At the 1947 Annual Meeting of the Medical Society of the State of New York at Buffalo, for the first time the Journal and Directory featured an exhibit All the editors were present at the meeting and were afforded the opportunity to speak personally to many of the members of the Society for whom they have been producing the Journal and to whom they had directed their editorials and editorial comment

Regrettably, but one copy of the forth-coming *Directory* was available and that one not complete. However, blue souvenir pencils, were thoughtfully provided, with the "Compliments of the New York State Journal of Medicine," so that any member of the Society wishing to express himself on any subject might have the means for doing so. Letters to the editors are always welcome whatever their contents, provided they are signed and are reasonably legible

Miss Willma L Simmons, the technical editor, was in charge of the Journal exhibit, which was to the right of the main entrance of the Memorial Auditorium. One panel of the three constituting the exhibit portrayed the "Journal Through the Years" and consisted of the covers of the Journal at various times in its history. By these covers, the typography, color of paper, and makeup, the changes that occurred in the Journal's appearance, size, and content could be

traced readily Another panel portrayed the Journal as it now is and limited a studious-looking member in the act of reading it Perhaps the editors will be pardoned this suggestive, even immodest advertising venture, the Publication Committee sanctioned it

The third panel showed the *Directory* as it will appear when distributed. It attracted a large amount of attention. One member stood in front of the panel, his hands behind his back, in silence for a long time. Abruptly, he turned on his heel and with an expression of sadness on his features strode rapidly away muttering. "I should hive so long?"

Another member, thin, tall, ascetic in appearance and manner, addressed us abruptly "You write for the Journal?" Modestly we allowed that we did Silence He stared at us a moment, then shook his head and left us without further comment, stowing our souvenir pencil in his waistcoat pocket

The exhibit seemed to be a forward step in bringing the Journal and its editors into closer touch with the membership of the Society. We hope that the souvenir blue pencils given away with the compliments of the Journal will serve as a reminder that your suggestions for the improvement of the Journal are always welcome.

#### CARCINOMA AND HODGKIN'S DISEASE

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IT IS well over a century since Hodgkin first described the disease of the lymphatic system which now bears his name. A considerable body of factual data has been amassed, but much fun damental knowledge is still lacking, particularly in regard to the cause and treatment of the The question of whether Hodgkin's disease is a truly malignant neoplastic disease or a manifestation of a still unrecognized infection is unsettled A considerable amount of laboratory findings suggest the infectious or virus nature of the process. An understanding of the cause of Hodgkin's disease has been hindered considerably by the failure to isolate a specific agent, by failure up to the present time to transmit the disease to animals, and by the absence of spontaneous occurrence in animals Nevertheless, microscopic features of the lymph node involved by Hodgkin's disease, the presence of typical Reed-Sternberg giant cells, and plasma cells, particularly endothelial proliferations, speak in favor of infection and against neoplasm

The coexistence of carcinoma and Hodgkin s lymphogranuloma in the same patient is very unusual The coexistence of multiple primary cancer is rare enough but certainly more frequent than that of Hodgkin a disease with other neoplastic processes This does not suggest that the presence of Hodgkin's disease is in hibitory to the development of cancer fact that Hodgkin a disease occurs usually in the younger age groups may explain the infrequency of cancer in the Hodgkin's patient. Also the short duration of Hodgkin's disease (average two to three years) explains in part the infrequency of cancer in the Hodgkin's patient Reviewing the literature, one finds few case reports of the coexistence of Hodgkin's disease and carcinoma

Azanrd Reig published a case of coexistence of Hodgkin's disease and carcinoma of the colon in a postmortem examination of a 58-year-old man.

Lloyd F Craver reported a case of a 28-year old woman who had careinoma of the breast and Hodgkin's disease of the ipsolateral axillary lymph node both proved by biopsies <sup>2</sup> The same author published another case of the coexistence of Hodgkin's disease in the right submaxillary region and adenocarcinoma of the colon in postmortem examination of a 53-year-old woman who died from perforation of the large bowel.

Rudolio Sammartino reports a case of a 62 year-old man who had a retroperitoneal Hodg

kin's tumor and metastatic squamous cell care; nome, the primary tumor of which was not found.

In the past few months the authors have observed 2 cases of Hodgkin's disease associated with mammary cancer

#### Case Reports

Case 1 -II II a 68-year-old white woman was first seen at the Brooklyn Cancer Institute of Kings County Hospital New York in May of 1945 com planning of painless multiple masses of five months duration in her axillary and supraclavicular regions. The physical examination revealed a poorly nour ished woman with multiple soft lymph node masses in both axillary, supraclavicular and inguinal regions The liver and spleen were not felt breasts were entirely normal. The x ray examina tion revealed no evidence of pulmonary, pleural cardiac or bone pathology Blood morphology count 3 260 000 white blood count 30,200, poly morphonuclears 84 per cent lymphocytes, 13 per cent, cosmophils, I per cent, monocytes, 2 per cent. The patient had been treated for diabetes mellitus with insulin for the last twelve years, her blood sugar was 225 mg per cent and urine showed 4-plus sugar The microscopic examination by biopey of a left axillary lymph node revealed loss of the follicular architecture and infiltration of the node with small round lymphocytes plasma cells, cosmophils and reticuloendothelial cells There were also noted occasional multinucleated Reed-Stern berg cells The capsule showed marked thickening and invasion by small round cells. The diagnosis was Hodgkin's lymphogranuloma (Figs. 1 and 2)

From June 14 to July 20 1015, the patient was treated with x ray therapy to her supraclavicular and axillary regions and showed temporary improvement

In October of 1945 during a periodical physical examination of this patient in the outputient department of the Brooklyn Cancer Institute a hard not freely movable, orange-sized mass was felt in her right breast. Needle biopsy was per formed and the microscopic examination revealed neets of cells which appeared to be inalignant in nature. These cells, polygonal in shape showed marked hyperchromatic nuclei. The diagnosis was carcinoma of the breast (Fig. 3)

The patient refused surgery and was put on the antireticular cytotocic serum therapy (A.C.S.) from October 1945 until March 1946. She showed some general improvement such as gain in weight, improvement in blood picture and rehef from pain While her general condition improved temporarily the mammary carcinoma extended progressively infiltrating her entire right breast, without showing evidence of any metastatic lesions.

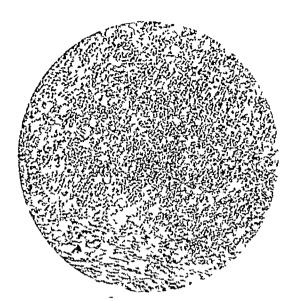


Fig 1 Microphoto (magnified 90×) of lymphnode biopsy, showing loss of follicular architecture, thickening of the capsule, and reticulo-endothelial proliferation

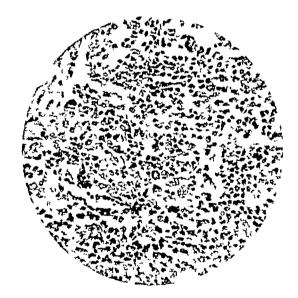


Fig 2 Microphoto (magnified 400×) showing the reticulo-endothelial proliferation, Reed-Sternberg giant cells, and plasma cells

In April of 1946, the patient became stuperous, she had convulsions continuously for forty-eight hours before death No autopsy permission was obtained

This diabetic patient had two conditions cinoma of the breast and Hodgkin's disease

Case 2 — The patient, a 40-year-old white woman, consulted J S in January of 1945, because of swelling of the right cervical area At the time of the exami-

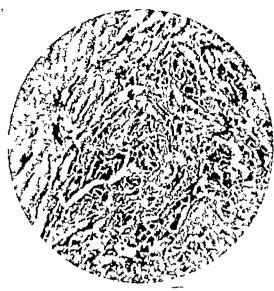
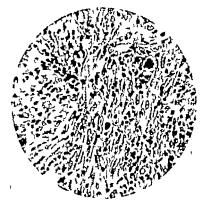


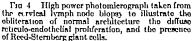
Fig 3 Microphoto (magnified 400×) showing needle biopsy of the breast. Note nest of cancerous cells

nation she had a nodule the size of a walnut in the right cervical posterior triangle and a pyrenia of 101. The breasts were entirely normal. The red blood count showed a hemoglobin of 90 per cent, red blood count, 4,250,000, white blood count, 9,000, poly morphonuclears, 72 per cent, lymphocytes, 12 per cent, eosmophils, 10 per cent, monocytes, 6 per cent. No abnormal forms of cells were found. The heterophilic agglutination test for infectious mononucleosis was negative.

The cervical mass was excised and was reported as follows—complete loss of architecture, diffuse overgrowth of small lymphocytes, marked reticulo-endothelial proliferation with tendency to fibrosis Numerous plasma cells, rare cosmophils, and polymorphonuclear cells—Many epithelioid and Reed Sternberg cells were found—Mitotic figures were not uncommon—The diagnosis was Hodgkin's lymphogranuloma (Fig. 4)

The patient remained quiescent for the ensuing year, during which interval she received small amounts of x-ray therapy to the right cervical region Repeated x-ray of her chest and blood counts showed no abnormalities In March of 1946, an enlargement and some induration of the lower outer portion of the right breast was noted right breast being about 30 per cent larger than the left, the physical examination revealed a single, very hard nodule, with restricted mobility, surrounded by engorged soft mammary tissue It was first thought that the condition was due to lymph stasis from blockage of the lymphatic drainage of the axillary There was no other evidence of disease, no lymphadenopathy, and x-ray films of the lungs and mediastinum once more were negative Blood count was normal As the frozen section of the breast tissue showed carcinoma, a radical mas-





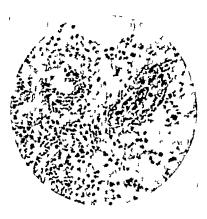


Fig 5 High power photomlerograph taken from the breast tissue to illustrate the duet cell carcinoma.

tectomy was performed. The microscopic study of the specimen showed long segments of ducts lined by carcinomatous cells No involvement of the axillary nodes by carcinoma was found (Fig. 5)

This patient also had two conditions a carcinoma of the breast and Hodgkin a disease of the lymph nodes.

#### Comment

The association of carcinoma with Hodgkin s disease is believed to be very rare. The rarity of the coexistence of these two diseases may be explained by the age of meidence by the duration and by the nature of Hodgkin's disease

We have no evidence to believe that Hodg kin's disease has an anticarcinogenetic effect in Nevertheless the fact humans or vice versa that the coexistence of these two diseases is so unusual is very striking and further clinical observations of these facts would be of great value to investigators of the Hodgkin s problem

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#### THE GOOD HOSPITAL

What makes a hospital good? It surely is not its display of worldly goods—its terraced stores of brick and limestone and mortar agleam with the brilliance of shining metal. It is not its bed capacity nor the longevity of its clinic patients. It is not the efficiency of its credit office nor the speed of its ambu lance service. It is not the number of births recorded or deaths certified to by the pathologist or the square yards of film exposed to the x ray — It is not the size of its endowments (although many a hospital could well utilize increased endowed funds while hospital costs are rising so rapidly) nor is it the aire of the internand resident staff and the complex 'teaching' schedule arranged for them.

The members of a good hospital staff are composed

of good doctors and, as good doctors, practice good

The member of a good hospital staff commits him self to the type of medical practice which will not bring discredit upon his fellow members. He practices his art with purity and with holiness—in the wording of the Hippocratic Oath. He eschews the shady and the gaudy the slipshod and the irrelevant knowing that these aberrations accomplish nothing for the betterment of his patient the in crease of his professional stature or the professional repute of the hospital staff of which he is a member

The good hospital is staffed with men of this spirit. -WILLIAM BROWNE

-Detroit Medical News April 14, 1947

# THE NEGLECTED PROSTATE GLAND

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ITH the great advance that has been made in preventative medicine during the past fifty years such diseases as typhoid, smallpox, and diphtheria are seldom seen by the present-day physicians, and tuberculosis is steadily being During the past one hundred years eliminated the average length of life has been doubled Statistics of the Metropolitan Life Insurance Company for 1944 give the average length of life as sixty-five years, women were hving longer-68 95 years, and men, 63 55 years If the present rates continue, by 1960 the average lifetime will be close to seventy years This situation is focusing the attention of medicine on genatrics, which is the care of the aged, and on geratology which is preventative genatrics

The prostate gland plays a very prominent part in the causation of the handicaps which men suffer in the later decades of life. Urologists estimate that 35 per cent of men over 50 years of age suffer from hypertrophy or, more specifically, hyperplasia of this organ. Of this number 10 per cent die of cancer. At present the prospect of a cure of this condition is most discouraging. An early radical removal is the only hope, hence the need of an early diagnosis.

Hyperplasia of this gland is not a disease per Due to its location an enlargement produces interference to the outflow of urine which, in turn, produces a chain of pathologic conditions that make old age a misery and frequently causes death unless relieved Applications of the principles of preventative medicine can greatly ameliorate this situation The medical profession should become prostate conscious as it has in focal infections, cancer, and tuberculosis Among the larty there seems to be abysmal ignorance as to the early signs and symptoms of urmary obstruc-Many seem to think it only the inevitable symptom of old age The urologists estimate that 25 per cent of men suffering from this condition do not seek advice until complete obstruction Among medical men there seems to be a very prevalent aversion to making a rectal examination with the gloved finger, as evidenced by the history of cases suffering from cancer of the rectum, internal, and even external hemorrhoids They frequently report several consultations with only a visual inspection of the anal region If, in the treatment of every man patient over 45 years of age no matter what the complaint was, a brief urinary history were obtained and an examination of the prostate made, the patient could be alerted as to the danger signals and seek early treatment

There is nothing new or original in this paper It is based upon the treatment of only 74 cases. one of which came to operation after sudden obstruction and this might have been obviated except for impatience in awaiting restoration of Two were cases of cancer normal function is impossible to reach reliable conclusions on such a small series of cases but a more widespread application would prove quickly whether the author's conclusions are too optimistic object of this article is to focus attention on a condition that is prevalent and will continue to become more so, and to outline a course of treatment that can be given by general practitioners in the office and with such laboratory aids as are daily employed in the diagnosis and treatments of other problems This paper is too brief to discuss the cause and morphology There seems to be some hope that this problem eventually will be solved on a hormone basis. It is sufficient to know that there is a hyperplasia of the glands and muscles producing periurethral pressure, intrusion of the enlarged gland into the urethra or into the bladder, which causes a slowing of the stream in force and volume, and difficulty in starting and shutting off flow, together with fre-There is, also, frequently lower abdominal and pelvic distress

#### Treatment

We are considering only simple hyperplasia It is necessary, however, to eliminate infection, stone, and cancer if possible before beginning treatment A complete history and thorough physical examination is as essential here as in any medical problems Advanced cardiovascular changes are frequent in these cases and must be carefully evaluated The first step, after history and a general physical examination, is a rectal examination noting the condition of the rectum The best position for this is the evaggerated knee chest position on the table or the standing elbow to knee It is fairly easy to acquaint one's self with the feel of a normal prostate When one recalls that the prostate is a seven-lobed organ and that one or all of the lobes except the posterior may be involved it is possible to realize the varied picture that may present itself. The posterior lobe is the one where cancer usually begins, but it does not become hyperplastic Note the size rounded or smooth, irregular or nodular, and the consistency—adherent or moveable If it is stoney, hard, or adherent, suspect cancer A punch biopsy and x-ray of the pelvis should be If the biopsy is positive the diagnosis is

settled, but one negative report cannot be relied upon. The x my will reveal metastases or atone if present Frequent checkup in these cases should be made

The patient should void in two glasses and a catheter passed to determine where there is a stricture, and the presence or absences of residual urne. If present it should be measured Should this persist during treatment an intravenous urogram will disclose diverticuli or hydrone-phro-us A phthalein or indigocarmine test will determine urnary function and a cystoscopic examination will reveal a median bar if present. This should be done by a urologist Urine analysis will disclose the presence of infection If present it must be determined whether the posterior urethm, the seminal vencles, prostate or kidney is involved

The milking of the prostate and seminal vesicles is frequently unsatisfactory. In the elbow-knee position with left hand on the patient shoulder, it is impossible to reach the seminal vesicles unless body pressure is made on the right elbow to relax the perineum with the three fingers. If the vesicles are reached frequently nothing appears at the meatus after milking the urethm. If there was any secretion it has regurgitated into the bladder. A smear of the centrifuged specimen of the voided urine will reveal infection if present. When infection does not clear up promptly the case should be referred. If a stricture is present it should be dilated gently by graduated sounds and checked for permanent relief.

It is well to remember that in passing a catheter or massaging these cases for the first time there is danger of creating an acute condition that might require hospitalization and the patient should be so informed. If there is persistent rotention of over 4 ounces an intravenous urogam blood chemistry, and cystoecopic examination should be made. If, after treatment, the residual remains around 4 ounces it is not a demand for surgery but it does demand frequent checkups and, in my opinion, the case should be referred.

The size of the gland bears no direct relationship to the obstruction A large gland may produce no obstruction while on the other hand a medium or small gland may produce a median bar with obstruction and retention Testoster one propionate, 25 mg may be given intramuscularly every two or three days until improvement and then reduced to once weekly This is rather expensive and if it is a faminual hardship stillbestrol may be given instead

The tolerance should be tested by beginning with 1 mg twice daily and increasing rapidly to 5 mg three times a day if tolerated — If improve-

ment occurs this may be reduced gradually to 5 ing once a day, to be continued two or three months with a rest week each month Occasion ally, the breasts become enlarged and painful These symptoms disappear on reduction of dos-Heat to the prostate can easily be applied by the patient himself with the use of the Eisner instrument. This is a hollow spoon-shaped device with an inlet and outlet nipple. It can be inserted easily into the rectum just beneath the With a large vessel at bed level filled with water between 115 to 120 F (the tempera ture of which can be maintained with a bath thermometer) and an empty one beside the bed the water is suphoned slowly From five to ten gallons should be used. At the end, a few gallons of water at room temperature is run through This produces a very beneficial hot and cold reac tion and may be given once or twice daily

Diathermy has been reported favorably by some observers but I have had no experience with its use. The use of deep a ray therapy by a competent roentgenologist has been enthusiastically recommended by some urologists few of my cases, who were nervous about irmga tions and massage, it has proved successful Massage has proved very helpful Just because the gland is so readily accessible is not an invita tion to assault and battery Any textbook will give minute details. It should be done gently the rectal mucosa should not be stroked, but a gentle pressure and a rolling motion of the terminal phalanx of the finger should be applied systematically to the whole surface of the gland If painful, a sedative suppository should be inserted one-half hour before treatment twenty treatments semiweekly should be suffi cient.

Sits baths properly given by the patient himself are also helpful. They can be given daily with the irrigations or on alternate days. A folded bath towel in the tub to sit upon adds to comfort. The water, as hot as can be withstood, sliculd not be over the crest of the ileum. Sitting down with knees drawn up, hot water is added as cooling takes place. Twenty to thirty minutes suffices.

A careful check on diet should be made, all excesses discouraged, and proper elimination advised together with moderate exercises. There is considerable divergence of opinion as to the reduction in size of the prostate dehieved by the use of testosterone, massage heat, and irrigation. In some cases there eeems to be slight reduction only, depending upon the amount of congestion previously present. However with the improvement in clinical symptoms, the question of estimated reduction is merely academic. One case report will concretely outline the treatment.

### Case Report

On July 27, 1945, C H, a man 64 years old was operated upon by the author under local anesthetic for a double inguinal herma. The right side was complete, direct, the left side indirect, incomplete On July 29 he suffered a large intestinal hemorrhage resulting in severe shock On July 30 catheterization became necessary There was hiccoughing for three days Stilbestrol, I mg three times a day, After a urologic consultation a bladder nas given splint was applied and the dose of stilbestrol increased to 5 mg three times daily The prostate was symmetrically enlarged and boggy Surgical removal as soon as the condition improved sufficiently was advised The patient refused to accept this decision Sutures were removed on the seventh day after primary healing The bladder splint was removed after eight days and the patient was allowed Use of sounds was begun to dilate an anterior urethral stricture. Daily sitz baths were given and Eisner tube irrigations begun blood chemistry was normal

A mild cystitis developed After catheterization 20,000 units of penicillin were instilled in the bladder The infection cleared up in a week The patient was now taking 5 mg of stilbestrol three times a day and strychnine sulfate, 1/20 of a grain three times On August 21 a barium cnema followed by a gastrointestinal series and proctoscopic examination failed to reveal the source of hemorrhage. The residual urine at the time was 600 cc. The improvement was rapid after starting irrigation. The residual urine steadily decreased The size, force of stream, and ability to void improved On the day of discharge, September 10, the residual urine was 50 cc This man was given prostatic massage semiweekly at my office for three months He continued the sitz baths and prostatic irrigations during this time on alternating days Sounds were passed once monthly. The prostatic irrigations were discontinued after a month but a sitz bath was taken daily Stilbestrol was reduced to 5 mg twice a day, every three weeks, then rest for two weeks, then 5 mg There was no residual urine A checkup in July, 1946, showed no residual urine, the stricture was still patent, there was occasional nocturia, once or twice depending on the amount of fluids ingested, and urmation was normal. The prostate was very definitely reduced in size The patient is doing his regular work and feeling physically fit All medication and treatment has been discontinued

This was apparently a case of acute congestion superimposed upon a hyperplastic condition retention developed a review of the history revealed that he had had symptoms of an enlarged gland for There was increased frequency and inability to void in the morning before taking a bath or This difficulty was not present in the This history should have been elicited at the time of admission

### Summary

An attempt has been made to outline a treatment that has relieved and checked hyperplasia of the prostate in a small series of cases - It can be applied by all general practitioners. It is urged that every man patient over 45 years of age, irrespective of his complaint, be questioned as to his urmary habits and a rectal examination made The patient then can be alerted to the early symptoms of obstruction If in all hospitals it should become routine to record the urmary history of men patients over 45 and in the physical examination to state the condition of the prostate gland, a surprising number of hyperplastic prostates would be discovered and much suffering and serious illness prevented by early treatment

100 CENTRAL AVENUL

### TB DEATH RATE AT NEW LOW IN STATE

Record low death rates from tuberculosis were recorded during 1946 for New York State as a whole, for New York City, and for the State, exclusive of New York City

According to provisional data reported by the State Department of Health for 1946, there were 1,900 resident deaths from all forms of tuberculosis— 132 fewer than in 1945—in the State outside of New York City, or a new low rate of 30 2 per 100,000 population, as compared with rates of 32 7 in 1945 and 32 5 in 1944 The previous low rate was 31 9 in

1941, when there were 1936 deaths reported There were 5,551 cases of tuberculosis reported in the upstate area in 1946 as compared with 4,768 in 1945

In New York City during 1946 there were 3,655 resident tuberculosis deaths as compared with 3,875 in 1945 The new low rate was 47 0 as compared with 50 1 in 1945 There were 7,313 reported cases in 1946 and 7,203 in 1945, in New York City

The provisional tuberculosis death rate for the entire State was 39 5 in 1946—a new record—SCAA News, April, 1947

#### MANAGEMENT OF INFERTILITY ASSOCIATED WITH OLIGOSPERMIA

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IIL treatment of obgospermia to elevate the L sperm density has produced fairly poor re-Hotchkiss 1 summarizing the results of authors on the value of hormonal therapy for defective spermatogenesis states "there is no effective treatment for advanced degeneration of spermatic tissue and that improvement can be expected in only a few unpredictable cases" Oligospermia per se is commonly regarded as an important cause of infertility thus focusing attention on treatment of the man in such cases However, that oligospermia may be present in fertile matings was brought out by Hotchkiss? when he investigated the sperm counts of two hundred men whose wives were pregnant and attending the prenatal clinic. He found that 25 per cent of the men had oligospermia

During routine studies of sterile couples it was noted that a number of conceptions occurred despite oligosperinin. These pregnances usually followed uterine manipulation particularly tubal insufflation. In addition there were several cases of secondary sterility with marked oligosperinia in couples who gave a history of provious pregnancies following tubal insufflation. In view of the above, and the poor results of the treatment of oligosperinia by others and ourselves it was decided to attempt to assess the comparative value of treatment of the min alone, the woman alone and both the woman and the man simultaneously.

There were 48 cases of infertility associated with objospermia selected from the Storility Clinic of the Bronx Hospital and our private practices. These cases were divided into three groups according to the following plans for therapy namely treatment of the husband alone (Group A) treatment of the wife alone (Group B), and treatment of the wife and husband (Group C) (Table I) Only couples who had complete studies and who received therapy were included. None of the patients who had investigation but no therapy were selected even though

| TABLE 1 | TABLE 1 | Treatment | Number of Cases | Number of Cases | Number of Cases | Pregnancies | Pregnancies

pregnancies ensued in several instances. None of the men except one with a basal metabolic rate of minus 15 revealed any discernible abnormality other than oligospermia. A man was considered oligospermic only when his semen count on two occasions following three or more days of sexual continence was found to be below 60,000 000 per

#### Treatment

Group A-IIushand Alone -There were eleven couples in this group. All the women were nor mal as far as could be ascertained. The only abnormality found was obgospermia in the man The sperm counts varied from below 5 nullion to below 50 million per cc. as noted in Table 2 Of these counts, seven were below 5 million one below 20 million two below 30 million, and one below 50 million In 10 cases therapy consisted of the administration of gonadotrophic substances. using 500 to 750 rat units two to three times a week for periods of from one to seven months not counting rest periods Rest periods were used during the course of therapy for the administra tion of pregnant mare serum to prevent the for mation of antihormones The gonadotropus used were equine chorionic human chorionic, or an terior pituitary hormone, either separately or in combination Thyroid was used in three cases one of which had a basal metabolic rate of minus One full-term pregnancy occurred following therapy indicating  $9^{1}/_{11}$  per cent success

Group B—Wyfe Alone—In this group of 25 cases there were 11 pregnances or 44 per cent success (Table 1) The sperm counts varied from between below 5 million to below 60 million per ce as noted in Table 2 Pregnances occurred in four couples where the sperm counts were very low two below 5 million and two between 10 and 20 million In addition to the object-permia of the

TABLE 2

8perm		Treatment	
Count per Ce. (Millions)	Husband Alone	Wife Alone	Both Wife and Husband
Below 5 5-10 10-20		••	••
20-30 30-40 40-50 50-60	•	***	

Pregnancy did not follow therapy

Pregnancy did follow therapy

men there were sixteen women who had some type of demonstrable abnormality. These abnormalities were pelvic infection (2 cases), tubal stenosis (2 cases), complete tubal occlusion (5 cases), marked cervical erosion necessitating congulation (3 cases), hypoplasia of the uterus (1 case), oligomenorrhea (2 cases), and obesity (1 case). One woman had three abnormalities and another two

There were nine other couples in this group in whom no demonstrable abnormality was found in the woman. Therapy was directed at increasing the fertility of the woman and resulted in one full-term baby. Attempts at increasing the fertility in those women in whom no abnormality was demonstrable consisted of administration of estrogens, 10,000 IU, or its equivalent every three days for 3 to 4 doses, the last injection to be given before ovulation, thyroid to tolerance even though the metabolism was normal, cervical dilatation alternating monthly with tubal insufflation.

The correction of the abnormalities in the woman was carried out as follows pelvic diathermy, repeated tubal insufflation, cervical coagulation, administration of estrogens, thyroid, cervical dilatation, weight reduction, and x-ray therapy to the pituitary gland and ovaries

Group C-Wife and Husband -Treatment of the wife and husband was carried out in twelve couples with full-term pregnancies resulting four times, or an incidence of  $33^{1}/_{3}$  per cent (Table 1) The sperm count varied from below 5 million to 40 to 50 million per cc One pregnancy occurred with the count below 5 million, two with the count 5 to 10 million and one with the count 10 to 20 million Of the twelve couples, five women had at least one demonstrable abnormality these five, one full-term pregnancy resulted abnormalities were tubal stenosis (1 case), closed tubes (2 cases, 1 with hypothyroidism), and oligomenorrhea (2 cases, 1 with hypothyroidism) Treatment consisted of correcting the abnormality of the woman in addition to organotherapy of the man (Treatment of the man and woman are given above in Groups A and B)

There were seven other couples in this group in whom no demonstrable abnormality was found in the woman, with three full-term pregnancies resulting. In addition to organotherapy for the men, the women received therapy to increase their fertility.

#### Discussion

Although this study includes only forty-eight couples, it is suggestive that the greatest percentage of pregnancies is obtained when therapy is directed toward the woman. The single preg-

nancy obtained in Group A, in which the man alone was treated, suggests the difficulty in increasing the fertility of the man. In addition, the sperm count of the men after therapy, including all the successful pregnancies in Groups A, B, and C, did not increase sufficiently to convince us that the therapy used was effective in raising the semen count

Because the results following organotherapy of the man were so poor, an attempt was made to treat the woman alone with the idea that perhaps the fertility of this member might be increased sufficiently to overcome the lowered fertility of the man A theoretic way of conveying this notion is as follows. If one assumes that the figure for average fertility for the man and woman is 50 each, then pregnancy will occur if the combine l fertility figure is 100. When a min has a low count, and his fertility figure is 30 and his wife has a minimum normal fertility figure of 50, then a pregnancy will not result because the combined fertility figure is less than 100 Since it is our contention that the figure for the man cannot be raised very readily, perhaps that of the woman can be raised sufficiently above the minimal normal of 50 in order to attain the desired 100 in combination with that of the man

In the group in which attention was given to the woman alone, ten of eleven pregnancies occured in women who had some abnormality which was a factor in the cause of the infeitility Because all the pregnancies except one occurred in the women who had some abnormality which was corrected, we are of the opinion their fertility figures were raised above 50, therefore resulting in combined fertility figures of 100 or more when The other extheir husbands were included planation may be that their husbands were of normal fertility despite the oligospermia, and raising the fertility figure of the women to normal resulted in conception. In other words, these husbands are comparable to the group of men with oligospermia found in 25 per cent of the Hotchkiss group whose wives were pregnant and attending the prenatal clinic

Although the results of organotherapy in the man alone were poor, we believed that combined with therapy of the woman the outcome might be better The percentage of pregnancies was defimtely greater, but did not show any increase over the group in which therapy was given to the wife The semen count repeated in two of the successful cases after impregnation did not reveal any marked changes in density One of these men had received organotherapy for one year before he came under our care, without any pregnancy ensuing His wife became pregnant one month after the onset of therapy directed at increasing her fertility

There were four impregnations in couples in whom no abnormalities were revealed in the woman to account for the infertility Therapy in each case was directed at increasing the fertility of the woman In one case the man received orcanotherapy in addition. The routine used was

- Latrogens in small doses before ovulation-.2 mg of di-ovocylin [Ciba] every three days for 3 to 4 doses.
- Thyroid to tolerance.
- Corvical dilatation alternating monthly with tubal insufflation

Since conceptions have occurred even in several cases in which the counts were very low, artificial insemination with a heterologous donor is not ad vised immediately. If the woman has an abnormality correction of this abnormality may be the only therapy needed. On the other hand, if the woman does not show any causes to account for the infertile marriage therapy should be directed at increasing her fertility However, if this fails after an eight to twelve months' trial then the

problem of artificial insemination with a heterologous donor should be taken up with the couple In our series, there were two couples who agreed to artificial insemination after failure of a trial of treatment. In both cases artificial insemination resulted in pregnancies These two pregnancies are not included in our percentage of pregnancies following treatment.

#### Conclusions

The results of organotherapy in the treatment of olicomermia to date are very poor or completely ineffectual

Therapy should always be directed at in creasing the fertility of the woman unless there is a correctable cause for the olicospermia

The prognosis is best whenever a correct able abnormality is found in the woman

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#### REPORT TREND TOWARD RURAL PRACTICE BY RETURNED DOCTORS

The Bureau of Information of the American Medical Association, which provides the medical officer with information regarding areas needing physicians 'is sensing the trend of returned medical officers to move away from their recent venture in city practice to accept the opportunities of more active practice in smaller communities, according

to Virginia Shuler, director
Writing in the Journal of the American Medical
Association (May 17) the author points out
"Demobilization is not completely over Many
young physicians are still in the armed forces, and
a large proportion of the resident physicians doing
postgraduate work in hospitals are men who served in World War II According to the Directory Department of the American Medical Association approximately five thousand physicians have not

yet decided on a permanent location Already the Bureau of Information is sensing the trend of returned medical officers to move away from their recent venture in city practice to accept the opportunities of more active practice in smaller

communities

From studies of physician distribution the general picture for location of physicians during the year following \ J day shows an adequate supply of physicians in most of the states but reflects

a need for a more coordinated system of medical service in many of the rural areas. "Leaders of the medical profession interested in better rural medical service are working with the farm organizations to outline a program of activity to develop in rural areas an appreciation of modern medical service and the responsibility of the com-munity in planning a health program that will make the country physician a working partner toward decentralization of medical care from urban or large trade centers to the more rural sections of the population. The medical profession and the farm groups want to make rural medical service more adequate not only to the farmer but also to those who extend this service to the farmer

To F 8 Crockett, Chairman of the Committee on Rural Medical Service of the American Medical Association has recently announced that the Farm Bureau, the Farmers Union the Cooperative Milk Producers Federation and the Grange have each appointed two of their members to act in an advisory capacity to the Committee on Rural Medical Service of the American Medical Association committee will hold a meeting soon to outline and develop an active program for regional and local rural representatives. Thomas A. Hendricks Secretary of the Council on Medical Service, is working out a plan with the Committee on Rural Medical Service to coordinate the council s and the

committees regional meetings in order to develop through workshop conferences the most adequate extension of medical service to all areas In December 1946, the Bureau of Information began a survey through the local medical societies to determine the conditions and distribution of medical care in the rural areas of the country Through the cooperation of the secretaries of the state and county medical societies listings of areas which have requested physicians are available to help the doctor in selecting an area in which to

establish his medical practice.

Accompanying the Journal article are reproductions of several state maps showing the trend in locations of physicians from April 1946 to Janu ary 1947—the peak period of demobilization of dectors from the armed services. The article also carries comments by several state medical secretaries of conditions and distribution of physicians as related to medical care in their counties.

# TRIDIONE THERAPY IN INSTITUTIONALIZED EPILEPTIC PATIENTS

EUGENE DAVIDOFF, M D, Sonyea, New York

(From the Craig Colony for Epileptics)

TRIDIONE (3-5-5 trimethyl oxazolidine 2-4 dione) recently has been recommended as a useful pharmacotherapeutic agent in the control of epileptic manifestations Richards and Perlstein1 reported its efficacy in patients suffering from petit mal seizures and in cerebral palsies of They claimed that triextra pyramidal origin dione had less effect on the spastic forms of cerebral palsy

In a group of 40 patients with petit mal seizures, Lennov<sup>2</sup> reported that 11, or 28 per cent, were free of seizures and that 21, or 52 per cent, experienced at least a 75 per cent reduction in the number of seizures Ten patients, or 20 per cent, were helped only moderately He also observed that in a group of 10 patients who experienced frequent grand mal seizures, the results were disappointing According to Lennov, tridione is not DeJong<sup>3</sup> stated that patients with psychomotor manifestations were beneficially af-According to Thorne, 4 3 of 11 deteriorated epileptic patients with grand mal seizures were better during treatment with tridione than with other medication In 6, the seizures were equally well controlled by tridione Two were made worse

The purpose of this paper is to report the results obtained following the administration of tridione in 42 epileptic patients at Craig Colony Five of the 15 patients suffering from cerebral palsy had had no seizures during the previous year Thirty-two of the patients had received the drug for more than two months In 10, administration of the drug was discontinued before eight weeks had elapsed because of the toxic effects encountered

#### Method of Procedure

The patients were grouped as follows

	. 1,	- the Ware O- author up totto !! ?	
A	Orgai	nic or Symptomatic	
	Čer	ebral palsies	15
	(a)	Extrapyramidal type	
		(No seizures noted for one year)	5
	(b)	Cerebral spastic groups	10
В.	Funct	cional or Idiopathic	
	1	Petit mal stupors	7
	<b>2</b>	Psychomotor predominant sei-	
		zures	10
	3	Grand mal convulsions	7
	4	Myoclonias	3

None of the spastic cases chosen had Jacksonian seizures The convulsions were of the mild grand mal type in 6 of the spastic cases Twelve of these 15 palsy cases were children under 15 years of age

We have observed that many of our patients frequently manifest both grand mal convulsions and petit mal stupors during the course of their illness 6 However, the 7 cases of petit mal reported in this study were relative uncomplicated, and grand mal phases had not been observed in these patients during their residence in the institution or were at a minimum for one year prior to the administration of tridione

In our experience psychomotor seizures are frequently associated with or follow grand mal convulsions 5 However, in the 10 cases in this series, these so-called equivalent (psychomotor) phases were the predominant feature

After a careful preliminary physical examination, the patients were placed on 3 Gm of tridione three times daily After four weeks, if no untoward results occurred, the drug was given four times daily The next month the drug, if well tolerated, was administered five times daily The majority (30) of the patients received 0.3 Gm three times daily during the major part of the period of observation Apparently 0.9 Gm (15 grains) daily is the optimum dose 2 However, the dosage was diminished to 0 3 Gm to 0 6 Gm daily when untoward effects appeared and later gradually increased if necessary Records of blood pressure, pulse, and respirations were kept In many instances electroencephalograms were done and these findings will be reported in a subsequent communication Blood counts and urine examinations were done weekly. The eyes, particularly the eyegiounds, were checked prior to and following administration The patients were watched carefully for untoward or toxic effects Previous medication was not discontinued until it was felt absolutely safe to do so and then only gradually

#### Results

The results obtained in the various types may be classified as follows

## A Symptomatic Group

Cerebral Palsies -The best results were obtained in patients suffering from cerebral palsies Eleven of 15, or 73 per cent, of the cases in this group responded favorably Ten of the cases were improved markedly

Four of the five extrapyramidal types (dystonic

or athefold) and seven of the ten spastic types manifested improvement in their ability to coordinete and in their mental attitude. Only one of these 11 improved cases had a seizure during the administration of tridione However, the five extrapyramidal types had had no seizures for at least a year prior to the administration of tridi one

The musculature of the 7 improved spastic eases was more relaxed, and their guit improved They responded better to balancing tests and did not fall as frequently Two of the 4 unimproved cases were worse. In I spastic case the grand mal seigures were tripled. One of the athetoid cases developed a severe toxic reaction accompanied by dermatitis exfoliativa

Tridione was apparently of the most value in those cases of cerebral palsy in which convulsions either were absent, not severely manifested, or at a minimum Ten of the 11 patients who im proved were children under 15 years of age. Two children were unimproved. The results in the three adults were not as favorable children who manifested convulsions of more recent onset seemed to respond best

#### B. Idiopathic Group

Petit Mal Stupors -- Four of 7 patients with idiopathic petit mal stupors were improved Case 1 has had no seizures for more than six weeks, although during the first two weeks the number of petit mal stupors increased alarmingly Case 2 and Case 3 also experienced a temporary increase in petit mal abstractions prior to the marked diminution noted in the second month In these 3 cases, while the results were discourag ing during the first month, dramatic improvement was noted during the second month woman patients, cases 5, 6 and 7, who had never had a grand mal convulsion during their resi dence in the institution, manifested grand mal seizures. Case 7 developed status epilepticus following fifteen grand mal sergures and was critically ill for four days. Following the administration of intravenous barbiturates she recovered This was the only severe toxic reaction noted in the petit mal group

Psychomotor Predominant Types -The mental status of 5 of 10 patients who evidenced a predom mance of idiopathic psychomotor seizures was definitely improved. One had no episode in two months during the administration of tridione Another experienced only one period of excitement In the other 3 patients all of whom experienced only two psychomotor attacks during the period of therapy these episodes were consider ably milder A patient who has shown a tem porary period of improvement at the end of two

months experienced a severe prolonged episode of excitement and confusion and was considered as unimproved. In another patient, after mild temporary improvement, severe hysteroid features again became evident. While the results were encouraging in 5 patients, increased excitement was observed in I patient and serial selzures occurred in another. The condition of these 2 patients was considerably worse during the period of treatment with tridione

Grand Mal Convulsions -Of 7 patients with idiopathic grand mal convulsions, only two showed marked improvement | Case 3 responded in only a moderate degree and became somewhat stuporous for a period of four days, although slie later showed improvement. The other 4 patients appeared to be worse following the administra tion of tridione Its administration was discon tinued in these patients. Case 7 developed stetus epilepticus In cases 4, 5, and 6 of this group serial seizures, confusion and/or stupor supervened The greatest percentage of toxic effects were found in the grand mal type, as six of the 7 patients manifested untoward reactions

The contrast between the results obtained and the milder grand mal scieures of the symptomatic group and the idiopathic grand mal types of convulsions discussed in this section is interesting All 6 of the milder spastic grand mal variety re sponded well to trichone and 7 of the 10 patients who manifested grand mal seizures in the spastic group improved In only one was a marked toxic reaction observed

Myoclonias -None of the three myoclonias responded favorably to the drug One patient (J W) suffering from the hereditary form was definitely worse. He became markedly confused and stuporous and the drug had to be discontinued (toxic reaction 8) In another case the continuous daily myoclonia was not diminished by tridione

#### Effects of Tridione

Evaluation of Results -The results obtained following the administration of tridione are sum marized as follows. In 23 of the 42 cases the response was favorable in 19 marked improvement was observed. The patients with cerebral palsies seemed most beneficially affected particu larly children and milder cases Eleven of the 15 or 73 per cent, of these organic symptomatic or palsy cases improved

Of the remaining 27 patients who may be classified as idiopathic or functional 12 or 44 per cent responded well About half of the patients with petit mal and psychomotor seigures were im proved Grand mal types and myoclonias manifested the least degree of amelioration of symptoms

Few of the patients in this series were very early or very mild cases. In all of them, seizure phenomena had been present for at least two years previous to the administration of tridione. Since many of these patients had not responded at all to other forms of therapy, tridione may be said to possess some ment. Further study to determine its ultimate usefulness is indicated. About 50 per cent of the patients responded better to tridione than they did to previous drugs such as phenobarbital and/or dilantin.

Evaluation of Toxic Effects—Our experience indicates that some of the favorable effects of the drug were counterbalanced by the untoward reactions which ensued The toxic potentialities of tridione must not be overlooked and the patients must be observed very carefully

In 10 patients the administration of tridione was discontinued permanently because of severe untoward effects. In 7 other patients, treatment with the drug was suspended temporarily but tridione was readministered in reduced dosage (0 3 Gm to 0 6 Gm) daily after a rest period of one week. A total of 32 patients complained of unpleasant side-effects during the course of the therapy

The side-effects were usually observed within the first two weeks of the administration of tri-In 9 patients delayed effects appeared during the second month of treatment but, except in 2 patients, these were of milder nature and were probably due to overdosage Temporary cessation of the administration of tridione or its administration in reduced amounts resulted in no serious side-effects However, the patients should be observed carefully for cumulative effects no case did toxic effects appear after another anticonvulsive drug previously administered had been gradually discontinued Patients who received dilantin concomitantly with tindione seemed somewhat more prone to toxic reactions tients who previously had received phenobarbital responded better

The untoward effects observed may be classified as follows

- 1 Ocular Manifestations While these occurred most frequently they were not the most alarming. The so-called glare phenomenon was noted in 24 patients. In 7 these subjective reactions, such as inability to see in bright sunlight, blurring of vision, white, milky, or green appearance of objects, and photophobia, were marked Dilatation of pupils occurred in 19 patients. In 1 patient a temporary papilledema was found However, in no case was the administration of tridione discontinued solely because of these ocular manifestations.
- 2 Increase in Seizure Manifestations Nine patients manifested an increase in grand mal

phenomena The most severe untoward effect was the occurrence of status epilepticus which was observed in 2 patients In 1 of these the outcome was fatal Serial seizures occurred in 4 patients In 3 additional patients there was a significant increase in the number and severity of Increase in petit mal seizures was the seizures noted in 2 patients In 3 there was an increase in One of these had rarely myoclonic seizures shown myoclonic reaction, but had four such attacks in the first month following the administra-Three individuals who prevition of tridione ously had manifested only petit mal seizures manifested grand mal phenomena

- 3 Increase in Mental Signs Untoward psychologic reactions and temporary abnormal behavior were observed in 6 patients. Three exhibited severe episodes of excitement. Four were markedly confused and manifested stuporous reactions.
- 4 Generalized Untoward Reactions A total of 32 patients manifested a combination of more or less generalized unpleasant reactions or sideeffects The subjective complaints observed are listed as follows

Irritability	11	
Fatigue and malaise	9	
Headache	9	
Drowsiness	8	
Nausea and gastrointestinal symptoms	6	
The objective signs were classified as follows		
Changes in blood pressure	32	
Changes in blood count	25	
Changes in temperature	22	
Dermatitis	6	
Albuminuria (transitory)	1	

In 24 patients the blood pressure was decreased by more than 15 mm of mercury In 8 patients it was elevated more than 15 mm In 4 patients the systolic blood pressure was decreased to 65 and in 3 patients the diastolic blood pressure was reduced to 40

The blood changes were of interest and were mostly concerned with the white cells. In 24 patients there was a 2,000 to 5,000 decrease in the white cell count. In 13 this decrease was transitory, but in 11 the depression of the white cell count was more than temporary. In 4 patients a temporary increase was noted. In 13 a white blood cell count of below 4,500 was observed, and in 3 the white cell count ranged from 3,000 to 3,500

Increase in lymphocytes and decrease in the polymorphonuclear leukocytes were noted in 17 patients. Decrease in lymphocytes and increase in polymorphonuclear leukocytes were observed in 11 patients. In 7 the blood smear revealed mild eosinophilia. In 8 patients the monocytes

The red blood cell count in were increased creased in 3 nationts and was temporarily diminished to 3 000,000 in 2 patients (a diminution of approximately 1,000,000 from the previous level)

The rectal temperature was below 97 5 F in 12 patients. It fell as low as 96.5 I in 3 of the patients. A temperature use of more than 3 \( \Gamma \) was observed in 10. Six patients complained of "chils and fover" In 4 patients the temperature exceeded 103 F and in the individual with exfoliative dermatitis it rose to 105 F

In 6 patients more than moderate skin reactions were noted. One patient developed a severe scarlatina-like rash followed by dermatitis exfoliativa Another patient developed a severe acneform skin reaction of the face accompanied by macular crythematous rash of the body

Summary of Severe Toxic Effects The sequence of tridione side-effects in the 10 pa tients experiencing severe toxic results was as follows a feeling of general malaise weakness headache, slight incoordination a feeling as if they were about to fall eye signs, dizziness, epi gastrie discomfort, or nausca, skin rash, fall in blood pressure, decrease in white cell count, or lymphocytosis, followed by a fall or rise in temperature or by a "chills and fever" reaction, irri tability, and drowsiness. After two or three days of more or less general manifestations or vague "all gone feeling" quite auddenly either serial seizures status and excitement, or stupor confusion, and prostration supervened In 3 patients hyperpyrexia or subnormal temperature and der matitus were present

The toxic conditions mentioned in the discussion and in the tables which finally caused the cessation of the therapy in these 10 patients are summarized in Table 1 in the order of their seventv

#### Conclusions

- Tridione appears to be more effective in cerebral palsies or symptomatic epilepsies, particularly in children with milder types of organic impairment or milder seizures and when the manifestations are of more recent origin.
- In the idiopathic group (a) It was of some Value in about half the patients with psychomotor

	TABI F (			
Patient		Dosago	Toxi Reaction	
1	1.	0 0 Gm	Status epiler ticus (fatal)	
3	МЯ	0 9 Gm.	Statu epilepticus following general- ized toxic reaction including de- crease in red blood cells of 1,000 000 dermatitis and hyperpyrevia	
3	A. B	0 9 Gm.	Serial seisures followed by stupor and confusion	
4	G F	1 2 Gm	Serial seisures followed by stupor and confusion	
5	E. O	0 9 Gm	Serial seisures followed by excitement	
đ	JC	0 0 Gm	Severely excited mental state	
7 8 9	11 1	0 0 Gm	Sev rely excited mental state	
8	7 T	0 9 Cm	Confusion and stupor	
10	K 8	0 9 Gm	Stupor and confusion accompanied by Ills and fever—authormal ten perature, fall in blood pressure 65/40 fall in white blood cells to 4 000 increase in polymorpho- nuclears dermatitis Derr atitis exfoliativa, accompanied	
_			by hyperpyrexia (105 F) increase n lyi inhocytes, a decrease in white blood cells of 5,500	

attacks and petit mal stupors. (b) it appears to be of least value in grand mal seizures and long standing invocioning

- Children and the milder cases responded better in all groups. The degree of difference in improvement in children as compared to adults in the idiopathic cases was not as marked as in the spastic types However the number of children in this series was too small to warrant any defi nite conclusion with regard to the idiopathic cases
- Tridione produces toxic effects and untoward reactions which necessitate careful observation of the patient preferably in a clime or insti tutional regimen Until the effects of tridione are better understood and its action more carefully established tridione should be administered with considerable caution. Fewer toxic effects were noted in children
- Tridione ments further study to establish its importance in the treatment of the epilepsies, as in 50 per cent of the cases the patients reacted better to tridione than they did to previous medication, such as dilantin or phenobarbital

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#### INDIANA MEDICAL REGISTRATION

The State of Indiana recently has passed a law requiring annual registration, effective July 1 1947. The Secretary of the State Board of Medical Registration calls the attention of all Indiana registrants.

located in other states to the provision of this law, so that their licenses will not be revoked. For further information address Ruth V Lirk executive secretary 627 K. of I Building, Indianapoles, Indiana.

# THE TREATMENT OF LIGHTNING AND GIRDLE PAINS IN TABES DORSALIS WITH NIACIN

Louis Pelner, M D, Brooklyn, New York

ONE of the minor, yet baffling, problems of medical care has been the lack of effective medication for the lightning pains, girdle pains, and gastric crises of tabes dorsalis. These pains are of such severity that codeine and morphine often do not allay them. In severe cases, even chordotomy has been recommended for relief of these patients. In treating 2 of these unfortunate patients, I have used intravenous doses of macin (nicotinic acid) as a drug to produce vasodilatation. The results have been signally successful.

## Pathology

In spite of the fact that this disease is caused exclusively by syphilis, the method by which the spirochete produces the lesion is not known. In addition, none of the pathologic processes found in the spinal cord in tabes is pathognomonic for syphilis. The pathology that is found at necropsy is inadequate to explain why the tabetic crises come in attacks and are not continuously present.

The pathology as described in textbooks is usually that of tabes dorsalis in its later stages. The site of the early lesions is unknown. There is a degeneration of the posterior horn and posterior roots of the spinal cord. There is also a thinning of the spinothalamic tract. Changes in the anterior horn cells, roots, ganglia, and sympathetic chain have also been described.

Chordotomy has already been mentioned as a method of treatment of the lightning pains and other crises of tabes 1-3 There have been good results reported by the intraspinal injection of thiamin chloride 56 In reading the case histories of patients treated in this manner, the patient often seemed to experience a feeling of warmth in the extremities after the intraspinal Thiamin in large injection of thiamin chloride doses orally or subcutaneously was meffective One author reported that thiamin was useful intravenously 7 These considerations may mean that thiamin may be effective in the condition as a nonspecific drug

Gastric crises, another baffing symptom in tabes, has gone through a similar cycle of therapy Recently a patient with severe manifestations has been relieved by periarterial sympathectomy of the celiac axis and its branches <sup>8</sup> The end result was spectacular in this patient. Among the possible reasons for this successful result, the relief of vasospasm must be considered

Fever therapy and insulin shock treatment have also been used to allay the lightning pains <sup>9</sup> A degree of hypoglycemia which caused a slight somnolence and intense sweating succeeded in achieving an improvement in this condition Perhaps in these treatments vasodilatation was also the common denominator

Because of these theoretic points it was felt that macin might be tried for this condition

When it is injected intravenously in sufficient dosage, it uniformly produces a generalized vasodilatation. Subcutaneous injections and oral use of this drug are more haphazard in producing generalized dilatation.

## Method

The treatment used in this study was the intravenous injection of macin as the monoethanolamine salt, 50 mg per cc \* Injections were started with 5 mg and increased gradually twice weekly up to a maximum of 50 mg (1 cc) Within several minutes, a flush which lasted up to several hours was produced in each case After several injections the patient could dispense with analgesics. When the 50-mg dosage was reached, it was given weekly for four weeks After the injections were stopped, 100 mg of macin was given daily by mouth to prolong the effect.

## Case Reports

Case 1 -N W, a man, aged 52, first came under observation five years ago for a trophic ulcer and severe lancinating pains in the extremities was aware that he had lues fifteen years previously but had been treated madequately. In addition to the trophic ulcer, he had contracted, irregular pupils which did not react to light, and ataxia, Romberg's sign, and diminished knee jerks Tryparsamide was given for one year without effect, either on the trophic ulcer or the lightning pains Sodium iodide in full dosage was taken by mouth trophic ulcer finally healed with local treatment with penicillin soaks and ointments, and with sodium thiosulfate injected intravenously lightning pains, however, were not affected

Approximately one year ago macin was begun intravenously in a 5-mg dosage of the preparation described above. It was increased to 10 mg, then 15 mg, until 50 mg was reached. Injections were first given twice a week, then once a week for four weeks after the 50-mg dosage was reached. Ten

<sup>\*</sup> The preparation used was Nicamin distributed by Abbott Laboratories, North Chicago, Illinois

months ago all injections were discontinued but the pattent was placed on nacin tablets 100 mg per day. He has had no lightning pains since that time

Case 2 — M B a man aged 58 had lues when 30 years of age, but was treated only with several doses of mercury and bismuth His complaint was that he had frequent recurring, severe girdle pains encircling his left chest wall. He had the typical signs of tabes, i e positive Wassermann test of the blood and spinal fluid contracted, irregular pupils that did not react to light ataxia, and diminished knee jerks. Tryparsamide was given in full dosage for about one year, but this did not have any effect on the severe girdle pains. These would recur every few weeks and would last day and night for several days.

Niach was given intravenously exactly as in Caso 1 with signal results. The patient is now taking 100 mg of niach daily. He has been with out severe girdle pains for one and one-half years, although he does gut mild pains in inclement weather.

#### Comment

July 1, 19471

The two possible modes of action of macin are either as a drug to produce vasodilatation, or as a

specific vitamin in an avitaminosis. Both modes of action are possible in tabes, but most likely the effect is nonspecific. How visodilatation works to relieve the recurring seizures of lightning and girdle palas is unknown largely because the pathogenesis of these symptoms is likewise unknown.

#### Summary

Two tabetic patients having lightning and sovere girdle pains are reported as having been relieved by the intravenous injection of macin

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#### NEW YORK UNIVERSITY INAUGURATES INSTITUTE OF INDUSTRIAL MEDICINE

Officials of New York University recently inaugurated the Institute of Industrial and Social Medicine as a unit of its New York University Bellevuc Medical Center, and announced that Dr Anthony J Lansa, one of the nation s leading authorities in the field of industrial health, will join the Institute as professor of industrial medicine.

The dual announcement came at a luncheon June 3 at the Harvard Club when medical directors of some of the nation s largest industries with representative labor leaders heard Winthrop Rockefeller and Dr Loo S Price, director of the International Ladies Garment Workers' Union Health Center hall the announcement as evidence of increasing interest in industrial health as a factor in world production.

In announcing the new Institute and the appointment of Dr Lansa Dean Currier McEwen of the New York University, College of Medicine, said the Institute will offer training for both professional and lay workers, and will award appropriate degrees. There will be in operation in conjunction with the

Institute a new general group practice clinic, staffed by members of the College faculty. The general clinic will be in operation by next fall, he said and will offer to wage carners a comprehensive program of medical care. He added that there will also be offered a graduate program, not only to qualified physicians, but to others wishing to specialize in the field. The Institute will also offer industry special services covering research in toxicology, physiology worker psychology, and tropical medicine.

A voteran of both world wars, where he propered in industrial health work, Dr Lausa holds the Legion

A voteran of both world wars, where he moneered in industrial health work, Dr Lausa holds the Legion of Merit and in 1946 received the William S Knud son award for the most significant contribution to the field of medicine. He is associate medical director of the Metropolitan Life Insurance Company

Dean McEwen announced that Dr Lanza will give voluntarily half time service until the end of 1948, after which he will be able to devote his full time to the new program of the College of Medicine. He will act as colinector with Dr Henry E. Meleney professor of preventive medicine

# A SIMPLIFIED TECHNIC OF TREATING SINUSITIS WITH PENICILLIN AEROSOL

With a Description of a Foot Pump for Economical Nebulization of Penicillin and Other Therapeutic Aerosols

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N PREVIOUS reports a method of producing L negative pressure in the accessory sinuses during nasal inhalation of penicillin aerosol was described Specially constructed valves were used to change the direction of oxygen flow from a venturn so that positive pressure was produced for nebulization of antibiotic drugs and negative pressure to withdraw air from the sinuses for subsequent replacement with penicillin aerosol 1-3 The source of negative pressure was derived from the side-arm of a glass (or metal) venturi tube which was itself connected by pressure tubing to an oxygen regulator As oxygen passed through the vertical length of the venturi, the constriction at its distal end created a negative pressure in the horizontal arm The valves were used to switch the delivery of ovygen through the nebulizer. when penicillin aerosol entered the nose, to the source of negative pressure, which was transmitted to the sinuses

Recent study of the apparatus indicated that the valve may be eliminated. Rubber tubing connects the horizontal arm of the venturi with the nebulizer, which is in turn connected with the glass trap and nosepieces, as seen in Figs. 1 and 2

The treatment is conducted by first holding the thumb over the distal end of the venturi, thus forcing oxygen through the nebulizer while the patient takes three or more breaths through the mouth, filling the nasal passages with penicillin aerosol. When the finger is removed, oxygen passes out of the open end of the venturi tube, and a negative pressure is transmitted directly from the side-arm of the venturi through the nebulizer to the nosepieces, nasal passages, and sinuses

Since a small amount of penicillin enters the venturi during the negative phase, it should be rinsed daily with hot water to prevent clogging. The nebulizer may be cleaned similarly each day

A flow of 5 to 10 L per minute is used to provide suction as the patient swallows, when the finger is released from the venturi tube. The venturi varies somewhat with different manu-

facturers, that flow is used which provides recognizable suction in the nose \*

The technic described substantially reduces the cost of the original equipment, since the valve is not used

The use of oxygen from a high-pressure cylinder has several advantages for continuous nebulization of penicillin solutions, namely, effortless delivery of the aerosol, the physiologic effect of ovygen in cases of pulmonary insufficiency, and the opportunity for a precise regulation of the flow of ovvgen desired However, for patients of limited means treated at home, the cost of rental of equipment and of oxygen is at times burdensome more economic method consists of the employment of the foot pump customarily used to inflate automobile tires as the source of pressure for aerosolizing penicillin, either for oral or nasal inhalation, the latter in conjunction with the negative pressure technic described above for the treatment of sinusitis 1-5 The handbulb of the conventional nebulizer may also be used if a small amount of solution is employed, such as 0 25 cc of water containing 20,000 units of penicillin cc \*\* The foot pump contains a piston which can be compressed by the ambulatory patient who is not acutely ill or enfeebled by severe, chronic disease Under the latter circumstances, it would be possible for a member of the family to operate the pump if the expense of oxygen equipment were prohibitive

The foot pump is mounted on a sponge rubber base or bath mat to prevent it from slipping on the floor. As seen in the accompanying illustration (Fig. 3), it is connected by pressure tubing to the nebulizer which is employed for aerosolizing

This communication is derived from a study of inhalation of pencillin aerosol supported by the Josiah Macy Jr Foundation

<sup>\*</sup>The assembly may be obtained from the Inhalational Equipment Company, 248 East 119th Street New York City the Oxygen Equipment Mfg Corp., 405 East 62nd Street. New York City, and the Vaponefin Co. 6812 Market Street Upper Darby, Pennsylvana These firms may also supply the automobile foot pump

<sup>\*\*</sup> Highly concentrated solutions such as 20 000 units per cc may be employed when a crystalline tablet is inserted into the nebuliser which prevents the waste that would ensue if it were transferred from an ampule by syringe. The tablets are supplied by Premo Pharmaceutical Laboratories, Commercial Solvents Corporation and Bristol Laboratories



Fig. 1

the solution A rebreathing but may be used with the nebulizer to permit reinhalation of the acrosol not absorbed during the first inspiration

The patient presses his foot downward on the piston during inspiration and raises it during expiration

With the sinus apparatus, which provides negative pressure for evacuation of air from the sinuses and replacement with ponicillin acrosol, the foot pressure is used both for delivery of penicillin abulin and for subsequent development of negative pressure. The venturi tube is opened, thus connecting the patient's masal passages with the venturi that produces negative pressure as the foot compresses the piston. When the tube opening is closed by the thumb compression of the foot pump directs air through the nebulizor and produces a mist of penicillin in the nasal passages and lungs.\*

The effect of oral inhalation of 50 000 units of crystalline sodium penicillin on the blood level in 12 patients with bronchopulmonary disease, shown in Table 1, averaged 0 17 unit of penicillin per ce of serum after one hour, which compares favorably to the findings in a large series of cases in which nebulisation of penicillin was accomplished with oxygen. The crystalline sodium or potassium salt is unquestionably superior to the usual calcium or sodium salt previously used since it is less apt to provoke cougling and uniformly is followed by higher concentrations of penicillin in the blood

The inhalation of 50 000 units of penicillin in 1-cc. physiologic saline is followed by a rinse of 1-cc saline (or 1 per cent necesynephrin in cases

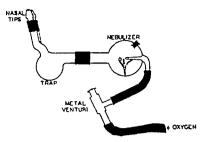


Fig. 2 bumplified negative pressure sinus unit



Fro 3 Foot pump for penicillin aerosol administration

with bronchospasm) to dissolve penicillin clinging to the small glass tubes. At the end 0.5-cc, saline or water is inserted into the nebulizer and allowed to remain until the next treatment. Unless a rinse of this character is carried out, approximately 30 to 40 per cent of the introduced ponicillin remains in the nebulizer and would be lost if the nebulizer were washed between treatments.

Vaporization of water from pencillin solutions due to nebulization by div oxygen results in a more concentrated solution of the drug in the nebulizer at the end of an inhalation. This is much diminished by passage of oxygen through a metal water bottle but the latter is not necessary as the saline rinse refusedves the concentrated pencillin. With the foot pump or handbulb air is used which contains water vapor in proportion to its relative humidity, and thus to some extent provents concentration of the drug. Sa

In some aut obile foot pumpe the piston is lubricated with graphite which enters the air stream, for this reason the air bould pass through a glass tube containing wood or ootton to filter out the dust particles or the pump hould be cleaned carefully before purchase

TABLE 1—Blood Levels Using Foot Pumi for Nebulization of 50 000 Units/Cc Crystalline PENICILLIN\*

Test Number	Blood Leve	els After Start of 1 hour	Inhalation 2 hours
1 2 3 4 5 6 7 8	0 I 0 05 0 1 0 4 0 2 0 0125 0 1	0 1 0 05 0 1 0 2 0 2 0 0125 0 2	0 1 0 0125 0 05 0 1 0 1 0 0125 0 1
9 10 11 12 Average	0 2 0 05 0 4 0 1 0 17	0 2 0 05 0 4 0 1 0 17	0 025 0 2 0 05 0 08

Commercial bolvents Crystalline Penicillin

line rinses, however, are still used to dissolve the greater part of the penicilin that adheres to the inner surface of the nebulizer

An incidental advantage of air over oxygen in the treatment of sinusitis is the fact that due to the absorption of oxygen from the Eustachian tube after treatment and the production of a slight negative pressure until air gradually diffuses into the tube, the ears do not develop the stuffy feeling which occasionally takes place when ovygen is employed

Since the function of the rubber bag in the apparatus used for the inhalation of penicillin aerosol has not been comprehended generally, it seems worth while to discuss this subject briefly Penicilin aerosol may be inhaled without the bag, the nebulizer being held within the mouth as the patient inhales the mist during inspiration is accomplished by the device of closing the open end of a Y-tube inserted in the rubber tubing from the nebulizer to the regulator at the start of the inspiratory cycle and removing the thumb at the end of expiration. The same purpose may be accomplished by turning the nebulizer on the side during expiration so that oxygen passes through it after the solution has been removed from contact with the small glass tube through which it is aspirated in the vertical position

Under these circumstances penicillin suspended in expired air is exhaled into the outer atmosphere, approximately 50 per cent of that which is In patients who are able to hold their breath after inspiration has been concluded, additional deposition of penicillin will take place in the lungs

Breath-holding is not possible for dyspneic patients, and becomes trying for the vast majority of others In order to afford the opportunity of reinhaling some of the exhaled penicillin aerosol, an enlarged glass bulb and later a rebreathing bag was used During expiration the patient delivers the unabsorbed penicillin mist into the rebreathing bag and during the succeeding inspiration inhales freshly produced penicillin

aerosol along with some of the aerosol from the rebreathing bag This may achieve a significant saving of the drug, especially in patients who cannot time their respiratory cycles accurately by placing a finger over the open end of the Y-tube at the very start or just preceding the act of in-The nominal expense of the rebreathing bag and glass tube connection is then counterbalanced by the loss of penicillin during respiration when the rebreathing technic is not em-The amount of rebreathing is limited naturally by the flow of oxygen, thus there is greater washing out of carbon dioxide and acrosol by a flow of 10 L per minute than at 6 to 8 L There is, however, no objection to dispensing with the rebreathing bag and using the nebulizer alone in cooperative patients

When the mask nebulizer apparatus is cmployed, penicillin may be nebulized continuously. with loss of the drug occurring in expiration, or use may be made of the demand valve nebulizer, in which penicillin aerosol is automatically produced during inspiration only During misk breathing it is desirable to instruct the patient to breathe through the mouth, or put cotton in the nose, as otherwise half of the penicillin inhaled is deposited in the nasal passages

## Summary

A simplified technic of producing negative pressure during nasal inhalation of penicillin aerosol is described for the treatment of acute and chronic The specially constructed valve previously reported is not necessary with this method

The use of an automobile foot pump is described for economical nebulization of penicillin aerosol, used either with oral inhalation of the drug or in conjunction with negative pressure during the nasal inhalation of penicillin ovygen from a high-pressure cylinder is preferable generally because of effortless delivery of the aerosol, this device is useful for patients of limited means since the cost of rental of equipment and ovygen at home may be dispensed with

Effective penicillin blood levels have been demonstrated after inhalation of 50,000 units per cc of normal saline by this method

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#### COOPERATION BETWEEN PATIENT AND PHYSICIAN

The Essence of Good Medical Care, Individual or Collective

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S RUDYARD KIPLING said some thirty  $\Omega$  and more years ago, the people of the world are divided into two classes patients and doctors In our own country the patients, i.e., the 90 9 per cent of the people through their elected legislators authorize the 0.1 per cent to practice medicine after giving evidence of possessing at least a minimum of knowledge and skill in the accences and arts required. The patients the people then permit a lot of other practitioners of the healing arts without even that minimum of knowledge required of physicians to offer their services to the sick, this is politically expedient but not intelligent The examination of physicians for the privilege of practicing medicine under the law is by physicians or nonmedical representatives of the basic sciences required in the medical curneulum

The educational policies methods subject matter, and teaching in the schools of medicine are the undertakings of physicians or nonmedical representatives of the basic sciences

This education of physicians before they can be heened to practice among the people, and the subsequent training of the recent graduate in hospitals and the still later postgraduate study by physicians for higher and specialty qualifications is all done under the control of physicians and their colleagues in the basic sciences

The people voluntarily and through taxation have supplied the financial resources for schools of medicine with their related hospitals laborationes and research institutions, and, yet, the cost of the medicial students education is higher than that of any other profession or occupation, not only to the institution of learning but in the matter of tution fees to the student and in his years of life

Once the physician is licensed to practice medicine he may live and work wherever he finds conditions to his liking, socially, economically culturally, or professionally and he is thereafter under no compulsion of law to pass examinations as to his competence or to alter his place of readence, so far as the latter is within the jurisdiction of the state or national board of examiners which passed upon his original qualifications

Briefly, then, the people, having set up what they consider sufficient formal requirement to protect themselves against grossly incompotent practitioners of medicine, have trusted to the wisdom of medical faculties and to the ambition and self-interest of physicians the education and distribution of practitioners of medicine to meet the needs of the sick

The experience of the people of the United States has been, on the whole, favorable under the present conditions which cannot be properly desembed as a system, physicians being now better educated, more widely distributed and in higher ratio to the population in our states than has been the case heretofore with any similar number of people in other lands or under other methods of control education, and distribution of physicians We can note properly in this connection that every index of health or relative freedom from preventable diseases and of longevity reyeals a state of affairs in the United States an perior to that of any such aggregation of people or of races elsewhere under single or multiple govern ment.

Two major complaints have been brought against the present medical care of the sick in our country, namely the unovenness of its availability geographically for some portions of our population and the cost of services of physicians and of medical institutions which are beyond the day-by-day resources of a large number of the sick to meet out-of pocket, or at the time of sickness and the receipt of the medical services.

It is to the correction of these that our first efforts should be directed to the end that sickness may be diagnosed correctly, and humane and skillful treatment be applied, wherever people are, regardless of the ability of the sick person to pay on the spot for the medical care required. This is a high ambition and worthy of the best brains and spirit of our times

Lest you think I have foresworn that particular field of medicine to which I am chiefly devoted, let me say that public health services as technically defined and provided for under austing local and state jurisdictions of civil government, offer the application of the sciences of preventive medicine through or with the consent of government for social ends. Public health is a community asset not a personal service. Public health is a social ambition to which the authority of sanitary laws and ordinances, their enforcement, and the force of public education and opinion contribute but individual and personal health is quite as much

Presented at a meeting of the Cooperative Health Group
Two Harbors, Minnesota, August 17, 1946

the product of physician-patient relationship as The term public health is is care of the sick loosely and improperly used to cover care of the sick by public authority or through tax momes, but it will clarify our thinking at this time, I believe, if we distinguish between the primary purpose of the physician among the people, which is to relieve suffering in sickness and aid the recovery of the sick individual and see that the approach of new life and of death receive all humane consideration and care, and the functions of physicians and others responsible for organized efforts for the control and prevention of the preventable diseases and the promotion of health in the mass by the use of authority and education Public health services authorized by civil authority are the background, the landscape of preventive medicine within which personal health is Personal health is the composite product of heredity, environment, individual character, and choice of conduct, and the following of the advice of that practitioner of human biology. the family physician

Health and its maintenance, its development, betterment, and protection differs essentially from sickness and its care in the economic and actuarial sense. The state of health is not an insurable risk, because at any moment a person insured may declare himself sick and claim benefits in money or kind, and no one can say him nay, or effectively declare him to be in health if he feels himself to be sick. The hazard of sickness is, to a degree, calculable as to its occurrence, duration, outcome, and cost

Insurance that means are provided to meet the costs of medical care of sickness is an honest and practicable project for thrifty people to undertake. Medical care of the sick offers the best opportunity to give guidance in personal health on the basis of a competent medical opinion as to the condition and capacity of the individual to achieve, or maintain, or improve it

Let us from now forward discard the dishonest. politically expedient, but misleading and intellectually deceptive, and confusing term health insurance, and commit ourselves, at least in the present state of our immediate and pressing concern, to insurance that medical care will be available and will be paid for Sickness insurance is understandable, although less precise a term than medical care insurance "Health msurance" in the sense of Lloyd George, of Beveridge. of that trio of impracticable political propagandists, Murray, Wagner, and Dingell of the 1946 vintage, is a term false and misleading, and implies medical services that cannot be delivered and promises that cannot be kept under any financial or administrative structure so far proposed

Neither public health nor personal health has been appreciably bettered by the introduction of the so-called health insurance plans in other lands, nor would it be as proposed for the people of the United States of America

We are here concerned with means by which care of the sick, which always should include personal guidance for health, can be more widely available and at a cost which the well rather than the sick can meet through prepayment plans by groups of persons over a period of time

There are two well-tested means by which the first objection to present conditions can be re-Physicians will go voluntarily to serve all people and to study sickness and its causes under even distressing and poor conditions of a social and cultural nature, if there is provided in the community or region a hospital, a wellequipped and staffed shop or medical power station where modern resources for aiding the diagnoses and treatment of disease are provided, and there is a group, which need not be more than half a dozen, perhaps only three, physicians serving the local hospital as a professional unit Such institutional and regional professional oiganization can be achieved for all but the most remote and sparsely settled parts of our country, with resources already planned for, and now actually authorized and appropriated to the Federal Government by the Congress (The Hospital Survey and Construction Act) and by the states, each state to report, after survey, its own particular necessities and present limitations in this respect Operation of hospitals for general sickness and for maternity care should be a charge upon local and state resources, not upon federal funds

Where the economic limitations of the people are extreme, as for instance where the per capita spendable income in the county or region is \$200 per annum or less, some form of public underwriting must be provided to offer the physicians salaries sufficient to attract and hold men of good character and education When, and if, the economic situation changes to permit the people to pay individually or collectively for the physician's personal services, the amount of the subsidy or underwritten salary would be reduced in proportion Distribution of physicians in proportion to the number and need of population groups should be natural and automatic and would probably be so throughout our country if the handicaps of no hospital facilities and inadequate income for the physician did not affect his choice of location to the disadvantage of the poor and lowly A temporary shortage of playsicians due to war and postwar military service and veterans' care demands has aggravated and emphasized the low ratio of physicians to population in many rural and low income areas of our country

The other complaint, that of a cost of medical care beyond the immediate means of the sick or their families, is being studied and overcome gradually for an increasing range of income groups, disease conditions, and kinds of medical nursing, hospital, surgical, and maternity servaces

The final solutions that are offered, if there be anything final in our times in a field of such wide variety and rapid social and scientific development, follow two distinct and incompatible organizational patterns and philosophies, the one based on compulsion and authoritarian control by government of the amount and quality of medical service, and of the cost of medical care and the manner of its payment which tends to become increasingly a direct charge upon general tax resources, and, the other a method of or gamzing and paying for some or all kinds of medical services by physicians and medical in stitutions through voluntary associations and insurance agreements between the consumers and the producers of medical care. Thus is our faith and resourcefulness and progress under our form of government put to practical test service plans undertaken for commercial profit or others by voluntary actions of individuals and groups are classified by Dr W P Dearing under five headings commercial insurance industrial medical service plans, private group clinics and consumer-sponsored plans community medical plans, and rural plans of the U.S Department of Agriculture.

It would appear from the incomplete evidence and records available that the group practice units furnish the best and cheapest medical services from the production point of view. For the other four varieties, the present interest is more in the financial structure than in the quality and results of medical care. It is well said, and in fact a fortunate blessing, that in a field of socioscentific endeavor so young and untried there are no experts.

Never was there a problem urgently demanding practical solution so apt and suitable for coopera tive approach by the two kinds of people defined by Rudyard Kipling the patients and the doctors the consumers and providers of medical care.

One cannot pick up a live publication dealing with the social and financial problems of medical care without finding enthusiastic description or overwhelming disapproval of some new experiment. The American Journal of Public Health

Controlled experiment, critical analysis and interpretation, corroboration, or the contrary, and logical reasoning on results are gradually replacing the quite hysterical political propaganda of the proponents of early national compulsory sickness insurance which has created a trail of disillusion, despair, and defeat for medical progress wherever it has been imposed upon a people in the name of public health welfare, and social justice. The buyers and sellers of medical care patients and doctors, are increasingly dealing directly with each other without government intervention.

We are here concerned with further and more promising experiments and even at the risk of repetition, I would wish to emphasize certain principles of relationship between consumer and physician groups which seem to me to be essential to any sound cooperative medical care undertaking

As the practice of medicine must always be an experimental and opportunistic profession because of the infinite varieties of sick persons and of the manifestations of disease, so we must in our social endeavors in this field accept the certainty of a wide variety of possible and practicable good, appropriate devices of service and pay ment, rather than submit to the anesthetic in fluences of a single pattern imposed from Wash ington and forced into uniformity of adoption by the power of centralized control Freezing of the warm enthusiasm for better quality and distribution of medical care, permeating every state and local community today by the glacial momentum of a federal pattern, which neither technical proponents nor legislative salesmen understand themselves as to its effects on patients and physicians, would be a cruel blow alike to the sick and their medical servants

Let us go forward with confidence in the value of forty-eight experiment stations in state government and in the unnumbered local social and economic groups who are striving for what is best in medical quality and at a cost they can meet. We should thank our bright stars that we are a federation of sovereign states with the certainty that there is no indigenous superiority of wisdom in Washington, but only the experience and resourcefulness of the home farm shop and cultural circle reflected remotely in the federal personnel and policies

Mutual trust confidence in frankness, and honesty of purpose of patient and physician are essential even before the use of laboratory tech-

of August, 1040, offers three plans for medical care under official auspices of a provincial, a state, and a city government, the patterns being radically different but each, perhaps, to be well received by the respective populations of Manitoba and Maryland and New York City

<sup>&</sup>lt;sup>1</sup> Dearing, W Palmer Am. J Pub Health 36: ~69-886 (July) 1946

nologies If there is the least barrier, reservation as to facts of history or symptoms on the part of the patient, or any shred of selfish or ulterior purpose in the questions and search for causes and facts of pathology by the physician, medical care ceases to meet its opportunity and obligation

In the same spirit and to the same end must every group or social effort for a better medicine and for bearable costs enter the discussion. The individual physician, the two or more in partnership, the medical staff of a hospital, the medical society of a county or state must meet the person, the group, the local welfare agency, the community as a whole, or in its self-preferred separate parts, the cooperative, the labor union, the employer, or management as nearly as possible in the manner and with the thoughts, hopes, and ambitions of the doctor and patient in office or at the bedside

Nothing less than the utter and comprehensive truth on each side can be acceptable. Each must be free. No one else may intervene, or determine, or control unless the patient wishes consultant or corroborative advice, and the physician is ready to accept such added presence. If the physician seeks added counsel the patient must consent. Either must be free to cease relations if these are not mutually acceptable.

May I suggest to patients, as a group of persons hoping or authorized to bring about some insurance plan for medical care, that they would be wise to consult persons with experience. rather than those with a theory to sell select a professor of the history of medicine with little or no experience in any kind of medical practice and a mere novice in American medi-Avoid a born and bred devotee of Teutonic governmental medicine, exiled by choice from his native land where his main employment was promoting and managing the medical plan that has been a major cause of two generations of medical deterioration in that very country eschew, even among our own physicians, those with but a minimum of the know-how and personal experience with medical care, although they may be endowed with a gift of ready speech Last of all, avoid lay persons of the philanthropoid type, whether in personal or organized voluntary or government service committed by the source of their income or by an order from the President of the United States of America to follow a line of thought, conduct, and expression Any one of such persons, whatever their university or government sponsorship, is less safe as consultant and adviser on medical care plans than are physicians and managers of hospitals, group clinics, and medical society projects, who have actually got down to the maternal facts of the situation and worked out a solution that is at least a going concern for care of the sick

When your watch is out of order go to the watchmaker, not to the plumber or carpenter

It is a primary function of the medical member to organize and provide the services. The patient partner can well devote himself to developing resources and methods of payment. Cooperative, shrewd, thrifty, critical adjustment between these two, without threat of strike, boycott, majority power, or recourse to political intervention should be possible over and over again under almost any of the different conditions characterizing our various communities and economies

The group clinic has been but the logical development out of the great benefits familiar to the organized medical, surgical, obstetric, pediatric, and consultant staffs of good general hospital and outpatient services

A consumer cooperative should be encouraged to undertake the sponsorship of a group clinic as hospital trustees accept responsibility for holding and operating a hospital, in each instance, the medical policies and standards of service being left to the unconditional determination of the physicians who accept positions on the staff The medical partner in the plan can more easily assure himself or themselves of the financial responsibility of the patient partner than can the latter feel confident that professional services are guaranteed as to quality by group discipline among the physicians, or through standards set up and, to a degree, enforced by organized county and state societies or by professional boards and associations

It is elementary that the medical group will assure the patient partner that no physician will attempt care of the sick outside of the field of his accepted competence

Whatever prepayment, or cooperative insurance plan is voluntarily undertaken must be inclusive, ultimately, if not at the outset. The patient, the person to be served, is a continuing altering, aging, growing, bearing, creating personality, requiring any or all the modalities of medical and associated care at any or all times, but needing these so far as possible in continuity, ie, under medical auspices that permit accumulated acquaintance with the patient's biologic picture and record over the years, and not merely episodically, for the brief times of acute invalid-Office, home, and hospital, outpatient, visiting nursing, convalescent, rehabilitation, dental, vocational, medical social service, laboratory, longtime care, and many another type appropriate to the patient's special need will have to be included if social and economic mechanisms

are to eatch up with the complexities of modern medical care. All under a single direction would be theoretically desirable but there is no basic reason to forbid the patient's participation in several plans, each fractional, if at some point there is the directing mind and heart and record that deals with the whole patient over the years. The good general practitioner and group clinic does this now.

It is taken for granted that medical plans like persons will have to share in the services of specialists, as few will be able to command, nor should they expect to control, the exclusive services of the brain surgeon who meets the needs of a million people, or the eucephalographist who is still rare and hard to find. Specialization will exist within the medical group and specialists will be called upon from the outside, but the decision as to need of specialty services should rest with the medical partner.

Medical care plans can with advantage originate from either party, being as properly born out of the desire of the doctors of the community for better scientific and economic efficiency as from the urge of patients to get better care within their means. Medical plans, since 1939, show a sturdness of growth comparable to but later than that of subscriber hospital plans of 1932.

Industries may fill the needs not met by other consumer groups but the principles will remain the same if good care, wide scope of service low administrative costs, and suitable payment of the producer group are achieved Labor umons themselves seem to prefer physician-operated plans, as must be the way if local government agrees to have the indigent sick so served

While so-called health education is a function of official and voluntary health agencies, and best through personal contact between the visiting or public health nurse and the family in the home there is a vast unreached audience, and a great mass of useful information which can be distributed only through the personal relation between the physician and patient, and of course through the mechanisms of intercommunication between subscriber consumers and the medical group they rely upon for medical care

Without laboring the matter unduly and to your unavoidable fatigue let me express my conviction yes merely a personal opinion that the cooperation of patients and their physicians in self-chosen groups can and will solve the problem of high quality of medical care and its sound financing without loss of any freedom or the intrusion of the Federal government between the two parties concerned It would appear that some nation-wide method, though not federal or national in origin will presently appear as a pattern for prepaid medical care. If such a plan is

to succeed it must have a place for autonomous cooperative organizations with the same purpose

It would seem proper, although not yet formally so declared by the United Nations through its official spokesman, that care of the sick and the relation of patients to physicians be accepted as concerning individual nations and not a problem for international promotion or determination. If federal and state governments are to be used as sources of revenue to meet local community costs of modical care of indigent or low income groups, there will be greater economy and efficiency of service if the funds are applied to existing approved voluntary programs, than if local government jurisdictions undertake added organizations for medical care under their own auspices

To avoid any possible misunderstanding of my personal opinions let me say that I believe any and every federal attempt to compel our people to support and the medical profession to serve a system of sickness insurance under whatever name should be opposed until Congressional consideration of such an undertaking is definitively abandoned. Time and the occasion do not permit detailed arguments against compul sory federal sickness insurance as so far proposed by legislation now for the second time more bund but not dead

The major points to be emphasized in developing increasing opposition to the Murray-Wagner Dingell bill until it is put permanently in the discard of things unwanted and unwise seem to me to be the following Such legislation if enacted would in my opinion

Lower the quality of medical care

Increase very substantially its cost

Create an administrative political bureaucracy Weaken sense of public independence locally and in states

I'ml to satisfy the demands for better medical care at less cost

Reduce the availability of physicians in wide areas

Make less efficient use of existing professional personnel

Fail to increase the number or improve the quality of the members of the profession in volved

Postpone almost indefinitely sound solutions of the problem under voluntary auspices

Repeat in the most intimate of all personal and confidential relationships that between physician and patient the blundering ineptitude chicanery and waste which have characterized each extension of the federal government into personal affairs for other purposes than taxation and the maintenance of law and order

To make any such legislation inexcusable and impossible, it is our immediate and continuing obligation to use all our individual and collective brains to provide for medical care through voluntary organizations of patients and physicians

Let us study the catastrophies in New Zealand and Australia, and learn from England's plunge whether again the British genius for muddling through will help us, but, by all means, let us prevent the fixation of a revolutionary blunder upon our own people in the name of social progress. Such action in regard to the voluntary hospitals as Britain has decided upon would be in this country at least a step backward and downward

The opinions I have expressed, I believe, are shared by more than 95 per cent of the medical profession in our country, and if the facts of the matter were as well understood by the people, well and sick, as they are by their doctors, and

there were any way of their expressing themselves freely on the matter, it might well be that similar opinions would be voiced by a similar majority of the people

In closing, may I refer to the relationship between prepaid medical care and general com-The health status of any community health munity cannot fail of striking and continuous improvement whenever the official authority and educational resources of the local department of health are supplemented by the services of physicians, nurses, and medical institutions for the sick made available to meet every reasonable need, and by the public spirit of a people wellinformed, self-directing, and organized to get the best that the medical sciences and services have to offer for treatment and prevention the kind of community which I conceive the Cooperative Movement is committed to create

#### PEDIATRICIANS TO HOLD CONGRESS IN JULY

With the United Nations struggling to share atom secrets that may destroy humanity, 2,200 leading child specialists from 50 countries will assemble at the Fifth International Congress of Pediatrics at the Waldorf Astoria, New York, from July 14 to 17 to share medical knowledge that should help preserve humanity. This year marks the first meeting of the Congress in America. Four previous Congresses have been held in Paris, Stockholm, London, and Rome.

Fourteen hundred delegates from Canada and the United States, 450 from Latin America, 250 from Europe, and 100 from other continents are expected Officially sponsored by the Pediatric Section of the American Medical Association, the American Academy of Pediatrics, the American Pediatric Society, and the Society for Pediatric Research, the Congress is stressing the One World theme in all its activities, recognizing that world health is an important factor in world cooperation.

The scientific advances made in pediatrics in the United States and other countries during the war period will be made available to all to insure the health of future generations. Pediatricians from all over the world will profit from learning how America

has applied pediatrics in private practice and in the public health field in decreasing community disease, instituting child health clinics, day nursenes, milk pasteurization, new feeding methods, etc. And American doctors will profit from the lessons taught to Europeans by the war ravages to child health.

The president of the Congress is Dr Henry F Helmholz of the Mayo Clinic in Rochester, Minnesota Two New Yorkers constitute the other officials of the committee—Dr L Emmett Holt, Jr, professor of pediatrics at New York University and chief of the pediatric staff at Bellevue Hospital, and Dr Donovan J McCune of the Babies Hospital at Columbia Medical Center

An outstanding feature of the Conference, according to Dr Rustin McIntosh, professor of pediatrics and Head of the Babies Hospital, will be accounts of the studies that have been made of malnutration among German, Dutch, Norwegian, and Danish children during the war

The American pediatricians, according to Dr McIntosh, believe every effort must be made to help foreign physicians at this critical time of conversion from the World War Era into the Post-World War Era

# WATERHOUSE FRIDERICHSEN SYNDROME COMPLICATED BY ACUTE PERICARDITIS. WITH RECOVERY

ISTOORE STEIN MD, Brooklyn, New York

THERE have been comparatively few reports of acute pericarditis complicating meningitis. Winslow and Shipley studied 62 cases of purulent peri None of these showed carditis bacteriologically meningococci. In reviewing 88 cases of meningococcemia, Campbell' cites only 1 with involvement of the pericardium Smith and McHugh! state that among 87 meningococcal infections 36 of which were accompanied by meningitis pericarditis was a complication in three instances Hernek<sup>4</sup> experi enced this type of cardiac complication in 12 out of 280 cases of epidemic cerebrospinal moningitis With only one exception the meningococcic peri carditis occurred in very severe cases and while the mortality of the entire epidenic was 24.8 per cent the mortality of the cases with the pericarditic complication reached 83.5 per cent Only 2 of these cases were recognized clinically as meningococcio penearditis Trace and Berkovitz' report one in-At Regional Hospital, Fort Ord California, there was 1 case of pericarditis among a group of 76 cases of meningococcic meningitis. This case has been considered worth reporting because of the infrequency of this type of complication and because the patient made a recovery from so fatal a diseasa.

Case Report

An 18-year-old white man was first seen on Feb 17 1945 at which time he presented a history of generalized aches, chills fever, sore throat and vomiting for several days provious. Drammation at that time roveraled essentially an acutoly ill patient, with a temperature of 102 F pharyngeal congestion and a slight degree of nuchal rigidity. Blood pressure was 72/50 pulse 144 and respirations, 30 A lumbar puncture revealed clear fluid under normal pressure, sugar 68 mg, per 100 cc. 12 cells, 3 polymorphonuclear leukocytes and 0 lymphocytes. White blood count was 27 500 with 87 per cent polymorphonuclears. The patient was given plasma, thamun chloride and 20 000 units of penicilin every three hours.

of penicilin every three hours
On the following day (February 18 1045) at 3 00
A.M. he took a sudden turn for the worse quickly
lost consciousness, and assumed an extremely agi
stated state, thrashing and kicking about wildly
To quiet him sodium amytal was administered in
travenously. At this time there were noticed in
merous homorrhague bullae scattered diffusely over

merous homorrhague bullae scattered diffusely over his entire body. The blood pressure was 130 per 92 On February 10 the temperature was 104 F and a spinal puncture revealed a turbid fluid. The blood culture taken on the previous day showed a growth of meningococci. In addition to the penicillin both intramuscularly and intrathecally and plasma, he was now receiving sulfadiashie and adrenal cortex. He remained comatose and irrational until February 23 1045. On that day the spinal fluid was clear. The skin lesions began to break down leaving scattered necrotic areas. From February 27 on his symptomatic improvement was mpid. How ever, on March 9 a percardial friction rub was heard in the left anterior chest. This disappeared two

days later There was no chest pain nor difficulty in breathing during this interval The skin continued to desquamate and was replaced by normal epithelium. He gained strength progressively and when last observed on July 17 (five months following the onset of his illness), he felt well except that he tired more easily than prior to his sickness

tired more easily than prior to his sickness.

Laboratory Studies — Urine and scrology (Kahn test) were normal. The original white blood count showed 27 500 cells with 87 per cent polymorphonuclears On February 21 the blood showed a growth of gram-negative diplococci typical of Acissoria. Subsequent spinal punctures revealed fewer and fewer cells and all pathologic elements disappeared by February 23. Roentgen studies of the chest were consistently negative. At no time was the presence of a pericardial effusion demon strated

Electrocardiographic tracing taken on February 18, while the patient was disoriented and in a semi comatose condition revealed a tachycardia, blphasic T2 and inverted T3 (Fig 1) On February

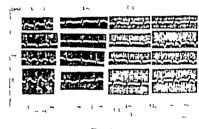


Fig 1

26, in addition to the above, T4 was also of low voltage. The cardiogram of March 5 indicated low voltage T waves in the limb leads and biphasic T4 At the time these aberrations were predicated on a toxic basis. On March 12 marked changes were noted in that all the T waves were inverted with alght rounding of RT2. This configuration per stated until April 2, when T1 and T4 were biphasic and RT2 slightly elevated (the rounding was not present) (Fig. 2). On April 9 T1 2, and 3 were inverted and T4 biphasic Tracings from May 11 on were essentially normal except for low voltage of the T wave in the second lead. Although the disappearance of the abnormal picture was alow, the scrial tracings described above were considered indicative of percarditis

#### Comment

This patient presented the picture of the so-called Waterhouse-Friderichsen syndrome "namely acute onset with high fever prostration, and unconsciousness, together with diffuse purpuric manifestations and overwhelming sepsis resulting from a meningo

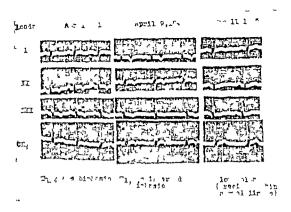


Fig 2

There were no symptoms related coccus infection to his pericardial infection, signs of which appeared during his early convalescence (twenty-two days after the onset of his illness) The diagnosis was predicated on the basis of the friction rub and the changing electrocardiographic pattern

markable recovery was undoubtedly due to the use of sulfadiazine and penicillin

#### Summary and Conclusions

A case of recovery from the Waterhouse-Friderichsen syndrome is reported The patient was treated with sulfadiazine (intravenously and later orally) and penicillin (intrathecally and systemically)

An unusual complication, pericarditis, was 2 noted and serial electrocardiographic studies were

700 AVENUE C

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#### MAJOR GENERAL BLISS NEW SURGEON GENERAL OF ARMY

Mai Gen Raymond W Bliss is the new Surgeon General of the Army, succeeding Maj Gen Norman T Kirk. His four-year term began June 1

Since January 1, 1946, General Bliss has served as Deputy Surgeon General General Kirk has retired

from active duty

General Bliss was born at Chelsea, Massachusetts, He was graduated from Tufts May 17, 1888 College, Medford, Massachusetts, in 1910 with the degree of Doctor of Medicine, and was commissioned a first lieutenant in the Medical Reserve Corps in September, 1911 He served on active duty until May, 1913, when he was commissioned a first heu-He served on active duty until tenant in the Medical Corps of the Regular Army He was graduated from the Army Medical School,

Washington, DC, in June, 1913
After tours of duty at various stations in the United States and Hawan, he entered the Harvard Medical School for a special course in surgery from August to December, 1920 He remained at Boston for further clinical study and instruction at Harvard until September, 1921 In October of that year he was detailed to the Veteran's Bureau where he remained on duty in the Hospital Division until 1922

Subsequent to World War I, General Bliss served as Chief of Surgery at Sternberg General Hospital, Manila, Phillipine Islands, at Fort Sam Houston and at William Beaumont General Hospital, El Paso,

Texas He was a military observer in London from September, 1940 to January, 1941, and became Surgeon of the First Army and Eastern Defense Command in 1942 He was assigned as Chief of Operations in July, 1943 and Assistant Surgeon General, August, 1944, in the Office of The Surgeon General, Washington, D C, serving in that capacity until his appointment as Deputy Surgeon General in January, 1946 He was made Assistant to the Surgeon General with permanent grade of brigadier general in February,

General Bliss, who was awarded an honorary Doctor of Science degree by Tufts College in 1943, is a fellow of the American College of Surgeons During World War II he made extensive tours of the Pacific Areas, and later served as an observer at the Atom Bomb Test at Bikini General Bliss has recently returned to Washington from a two-month inspection trip through the European and Mediterranean areas

General Bliss has been awarded the Distinguished Service Medal, Legion of Merit, French Legion of Honor, and the Award of the Italian Crown

#### PENICILLIN POISONING IN A CASE OF ACUTE STAPHYLOCOCCUS AUREUS HEMOLYTICUS INFECTION OF A HIP JOINT

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(From the Surgical Service of the New York Hospital)

PREVIOUS to the report of this case before the Regional Fracture Committee in February 1916, there had been a paucity of reports in the liter ature of cases of penicillin poisoning penicillin was considered almost infallible in its administration for infection. It was felt that the report of such a case had considerable value for the profession in proving that there is actually some danger in penicillin therapy

#### Case Report

W K N Jr, a man, aged 17, was admitted to the Now York Hospital October 18 1944 with the following history Four days before admission he had played a game of football, after which he felt perfectly well The following morning the right leg felt stiff and painful in the upper thigh antemorly He also felt stiff and sore all over became more stiff and the patient had a constant cramplike pain in the upper right thigh anteriorly He was unable to walk for two days after the onset his appetite was poor and he had run a tempera ture of about 100 F He had had difficulty in uri nating one day before admission

Previous History —The patient had a fractured

skull at three years of age, the therapy of which involved an operation About one month previous to present admission he had a carbuncle on the right thigh which was slow in healing because of constant aggravation of the area from football practice

Examination on Admission.—His temperature was 99 F, pulse, 72, respiration, 24 blood pressure, 140/70 The right leg showed marked involuntary muscle spaam, with tenderness over the sartorius muscle near its origin Motion was markedly limited in all directions by pain in the groin Blood count was hemoglobin, 15 Gm., red blood count, 5 400 000 white blood count, 11 2, lymphocytes 24 monocytes, 7, mature, 51, bands, 16

The diagnosis lay between early infection of the

hip joint or acute poliomyclitis.
On October 10 1044 the day following admission, the leg was put in traction by means of a Buck s ex tension with the relief of pain. His temporature rose to 102 F \(^1\) rays of the hip joint (right) were heractive for any pathology White blood count was 116 Urine was negative. The second day after admission the patient became very ill His tem perature went to 106 6 F with rapid and shallow respiration Blood pressure was 160/60 The heart sounds were booming with a suspicion of short harsh systelle murmur, and it was thought this might be the beginning of an endocarditis. Neurologic ex-amination by Dr. Henry S. Dunning revealed no evidence of disease of the nervous system. Treat-ment at this time consisted of 20 000 units of pencillin given every four hours five times a day blood culture was taken

On the third day a plaster of Paris spica was applied to the patient's hip which lessened the pain. He was also put in an oxygen tent which

Read before the Regional Fracture Committee for New York and Brooklyn at New York on February 21 1948.

relieved his respirations and pulse somewhat. The hip joint was aspirated at this time and bloody fluid obtained showing Staphylococcus aurous hemolyticus The blood culture taken on the pre vious day showed the same organism in 2 per cent dextrose broth in forty-eight hours. The blood plate showed only one colony after five days. All subsequent blood cultures were negative

After five days of penicilin therapy the supply gave out and a different penicillin was used of which he was given 25 000 units every four hours six times a day The new pencellin preparation was begun in the morning of October 25 and that night the patient developed generalized urticaria which during the following day seemed almost confluent At 2 30 A.M on October 27 he com plained of numbress of the hands and the left foot. At 11 00 a.m. that day the observations on neurologic examination by Dr. Henry S. Dunning were as follows The patient complained of paralysis of the arms and left foot, numbers of the arms up to the shoulders and of the left foot, and tingling in all of the fingertips of both hands. The trunk entire left thigh and right leg were enclosed in a cast There was paralysis of the following muscles

Right

Flexors of neck	Moderate	Moderate
Elevators of shoul der	Moderate	Moderate
Pectoral	Moderate	Considerable
Abductors of arm	Considerable	Complete
Flexors of forcarm	Moderate	Considerable
Triceps	Moderate	Considerable
Extensors of hand and fingers		Moderate
Flexors of hand		Moderate
and fingers		
All intrinsic mus-		Moderate
cles of hand		
Dorsiflexors of the		Complete
foot		
Plantarflexors of		Moderato
foot		
Extensors of toes	Considerable	Complete
Flexors of toes	Considerable	Moderate
		1 41 . 1.64

All the deep reflexes of the arms and the left ankle jerk were absent. The knee jerk was active and the plantar reflex on the left. No stretch reflex of the fingers or toes was elicited. Sensation to cotton and pinprick was decreased on the dorsal aspect of the left foot and first four toes There was no ovidence of meningtis or disease of the central nervous system. It was Dr Dunning's opinion that the patient was suffering from polyneuritis caused by an allergic reaction to the penicillin preparation which was similar to that which has been observed to follow the use of various serums (F Young, J.A.M.A 98 1180 (April) 1932)

On the eleventh day after admission the director of penicillm therapy at the New York Hospital saw the patient after he had received no penicillin for twenty four hours. The urticaria had cleared the neuritis had not progressed and the patient s temperature was rising again He felt that the patient still had a staphylococcus infection, which was localized and should be treated with penicillin believed that the penicillin reaction had occurred as a sensitivity phenomena to one of the previous types used Experience with other sensitivity reactions to penicillin had indicated that it was not the antibactericidal agent common to all, but unidentified products in some which served as the antigen. Changing from one product to another usually had served to prevent further evidence of sensitivity Therefore, despite the dangers involved, a retrial of penicillin should be made by several doses of 1,000 units, and if no urticaria develops the dose should be increased to 25,000 units every two hours twelve times a day

Intracutaneous tests were made with a new penicillin and a negative result was obtained. The new

therapy was begun with no further reaction For purposes of complete immobilization, a fulllength cast had been applied on the seventh day after admission from the axilla to the toes on the right side, and extending down to the midthigh on the left On the fifteenth day after paralysis appeared, a supportive splint was applied to the left ankle At this time x-rays of the right hip showed marked marginal bone absorption, with characteristic demineralization of infection, on the bones of the

hip joint On November 7, 1944, nineteen days after admission, a second aspiration of the hip showed bloody fluid but no pus, with the culture showing the same organism. In view of this fact and because of a rise in the patient's temperature, one week later an exploration by operation of the hip joint was done. This revealed only bloody fluid and an irregular erosion of the cartilage of the head of the acetabulum Ten thousand units of penicillin were placed in the hip joint and a plaster of Paris spica reapplied X-rays at this time showed increased narrowing of the hip joint with destruction of the bone Pathologic report of the specimen taken at the operation showed only hyaline cartilage

The patient's condition improved rapidly after operation and on November 30, 1944, or forty-two days after admission, penicillin was discontinued On December 2, 1944, forty-four days after ad-mission, x-rays showed the destructive process becoming arrested The spica was removed, December 17, 1944, or the fifty-ninth day, and the patient was allowed up with crutches

He went home on December 24, 1944 At the

time of discharge there was satisfactory recovery of power in the arms and in the toes on the right, but there was complete paralysis of the dorsiflexor muscles of the foot and of the extensor muscles of the toes on the left

The patient progressed well, gained weight, and gradually discarded the crutches and began to walk He was readmitted to the hospital on January 27, 1945, with a milder recurrence, having a temperature of 103 F He was given penicillin, 37,500 units, every three hours, improvement was rapid, and he was discharged February 10, 1945, fourteen days after admission

He then quickly recovered and went to work in midsummer and walked with the aid of a cane, he became extremely active until November 7, 1945, when he was again readmitted with a recurrence of pain in the hip and a temperature of 100 2 F He was again given penicillin, and the leg was put in He was discharged in sixteen days able to walk At the last discharge, he still showed a left foot drop and hypoesthesia over the distribution of the left superficial peroneal nerve

#### Summary

A case is reported of Staphylococcus aureus hemolyticus infection of the right hip joint with bacteremia treated by penicillin over a period of forty days with apparent recovery At no time did suppuration take place and at operation only erosion of the cartilage and bloody fluid were found in the hip joint

Penicillin sensitivity to one product caused an alarming polyneuritis which has resulted in a prolonged and probably permanent foot drop on the left

side

Heroic penicillin therapy again was instituted in the face of this serious complication

The importance of immobilization of infected joints in addition to penicillin therapy was stressed, for this not only tends to cut down the severity of the infection but prevents bad deformities when ankylosis takes place

A joint was left with limited active and passive motion after a Staph aureus infection of the right

There was relighting of the infection with apparent lessened virulence each time, penicillin being used each time without further reaction

# FALSE POSITIVE TESTS FOR SY HILLS AFTER VACCINATION

The New York City Health Department Aills the attention of physicians to the possible of false positive serologic tests for syphilis vaccination. About 40 per cent of primary reaction in who develop vaccinia (primary reaction to the Halocinoid (secondary reaction) following vaccine the Halocinoid (secondary reaction) following vaccine the Halocinoid (secondary reaction) in the property against smallpox may be expected to give the privace of the property of doubtful reaction in one or more of the tests for syphilis

This reaction may appear from one to two Occasionally it apweeks after vaccination pears before seven days or between the fourteenth and twenty-first day Those individuals who show

an immune type of reaction will not give a positive test for syphilis

A positive serologic report does not preclude the assuance of a premarital certificate since the diagnosis of syphilis is a clinical and not a laboratory func-If the physician finds that his patient does not have syphilis in a communicable form, that individual may obtain a premarital certificate regardless of the laboratory report

Since a false positive rarely appears before the seventh day following vaccination, it would be advisable to obtain blood before or within five days

after vaccination

#### FAUCIAL DIPHTHERIA IN ADULTS WITH REFERENCE TO THE EARLY DIAGNOSIS

Report of a Case with Complete Heart Block

JOSEPH GOLDSTEIN MD, and PHILIP L CALCAGNO, MD, New York City

(From the Willard Parker Hospital for Contagious Diseases Department of Hospitals)

THE incidence of diphtheria cases in certain sec tions of the United States has increased in 1944 and, particularly, 1945 For the country as a whole the excess in reported cases over the median for the corresponding months of 1940 to 1944 has increased during 1945 until it amounted to 30 to 45 per cent for the last months of that year 1 A recent reviews indicated that this increase in diph thema is expected to continue because of the high prevalence of diphtheria among the Germans and the veteran forces of the United Nations.3 Many of the returning American troops from Europe are undoubtedly carriers of virulent diphtheria bacilli irrespective of whether or not they have had the diseasc.

At the Willard Parker Hospital the incidence of diphthema is higher at present than it has been for the past five years A number of adult patients with faucial diphthena have been observed in whom a diagnosis was not made until late in the disease. The fact that this disease was not even considered until late in the course of the illness would warrant additional emphasis on the development of diphtheria in the adult age groups as well as in children. Therefore the criteria which aid in making a presumptive diagnosis before laboratory confirmation, and a review of the reasons for misconceptions are enumerated.

A case of diphtheria with severe complications in an adult is presented because of its several unusual clinical features

#### Case Report

A 33-year-old white man was admitted to Williard Parker Hospital on January 6 1946 with the chief complaints of difficulty and pain on swallowing, and hoarseness for three days. For ten days before ad mission, the patient had a cold during which time he was ambulators There was a persistent nasal discharge and three days prior to admission some difficulty in swallowing.

Seven years previously he had been hospitalized for dropsy for six weeks. On discharge, he was informed that he had a kidney disease. He was rejected by the Army and Navy recruiting stations for having albumin in his urine. There was no his-

tory of hypertension or rheumatic fever Preliminary physical examination revealed a fairly well-developed but poorly nourished, acutely ill man His face and neck on the right side, down to the sternum, appeared swollen and the overlying skin was covered by a thin crythema. The swelling was rather firm and ligneous, very tender and homogeneous. No point of fluctuation was noted. No creptitations were palpable. A mass of organized tissue appeared to project from the oral pharynx. This mass extended forward over the soft palate and included half of the hard palate. The portion of tussue adjacent to the oral pharynx seemed to be attached to the right tonsil The surrounding tissues of the throat for only a short distance beyond the mass were a lurid red color The anterior edge of the mass was lying free in the mouth just above the tongue. The other atructures of the pharynx were difficult to differentiate. His temperature was 103 F, pulse 124, respiration 24 and blood pressure 145/100 The heart was not enlarged no murmurs were heard and there was a regular The lungs were clear throughout. mnus rhythm There were no significant findings in the abdomen. No abnormal neurologic findings were present the etiologic agent was thought to be Corynebacterlum diphtheriae 75 000 units of antitoxin were ad ministered intravenously and intramuscularly Thirty thousand units of penicillin were given every three hours intramuscularly for ten days to check

secondary invaders.

After initial therapy the patient improved slightly and was more alert. However he complained of pain in the throat continuously and had a great deal of difficulty in swallowing. There was a constant flow of mucus and blood from the corner of his mouth He took fluid very well. Three days after admission he coughed up a thick fibrous tissue The following day ectopic beats were heard upon auscultation of the heart. The local infection seemed to have improved. The swelling of the neck had subsided considerably On the seventh hospital day idioventricular rhythm was recorded and rates of 10 to 11 per minute were noted. This continued for approximately forty-eight hours and then rose to 20 to 30 No attacks of syncopy or gastrointestinal symptoms were observed dition became progressively werse on the ninth hospital day. The patient became anuric and ex pired on the next day

Laboratory Data—Examination of the blood showed a red cell count of 4,050,000 with 76 per cent hemoglobin, and a white cell count of 9 400 with 77 per cent polymorphonuclears. The differentiation tial count was normal. Repeated urine examination showed a specific gravity of 1 010 to 1 016 albumin, 2 plus to 4 plus, 15 to 20 white blood cells, 2 to 8 hyaline casts, and numerous red blood cells. The blood Wassermann test was negative. On the ninth hospital day, the nonprotein nitrogen was 115 mg per cent.

Cultures from the nose and throat taken on ad mission revealed only Staphylococcus aureus. However from all subsequent cultures C diphtheriae of a mitus type, and toxic for guinea pigs, was re-

covered

Pathologic Findings —The necropsy and pathologic examinations were done by Dr Vera B Dolgopol. The membrane coughed up on the fourth hospital day was thick, fibrous, and well-organised tissue. It measured 4 by 3 by 1 4 cm. Microscopic examination showed meshes and layers of fibrin with entangled red blood cells and fragments of nuclei of white blood cells.

At autopsy the heart weighed 510 Gm. The right ventricle was dilated the left ventricle was

hypertropined, and the muscle appeared flabby and friable Microscopic examination revealed a degenerative myocarditis, especially marked in the interventricular septum, extending to the fibers of the conductive system. The kidneys were enlarged, the right weighed 320 Gm and the left 330 Gm, the capsule was slightly adherent to the cortex, and the surface was granular. Microscopic examination revealed marked fibrosis in the vascular tufts. Many glomeruli were obliterated and one third of them showed multiple adhesions to the capsules. The tubules occasionally showed some granular and hyaline droplet degeneration.

#### Comment

This case presented several unusual features The bradycardia recorded on the ninth hospital day was 10 to 11 pulsations per minute lasted for only a short time, and on the following days the ventricular rate rose to 20 to 30 per minute Only one other reference to such a severe bradycardia could be found in the literature, that of Drs Denechau and Raffauet & However, their case presented convulsive crises and a picture of Adams-Stokes syndrome These were not features of the case herein reported. It is interesting to note that the day the bradycardia became evident coincided with the time that the patient became anuric the absence of extensive acute tubular changes in the kidney, this could be explained possibly on the basis of decreased cardiac output and, consequently, decreased renal blood flow, due to diphtheritic myocarditis

The type of membrane constitutes another remarkable feature of this case. When this patient was first observed, many different suggestions as to its nature and pathology were advanced. The membrane was thick, dense, very firm, and appeared as another tongue protruding from the soft palate. The appearance suggested a neoplastic lesion, a fungous infection, a lesion due to blood dyscrasia as much as or even more than it suggested the presence of a diphtheritic membrane.

However, the diagnosis of diphtheria was entertained because of the presence of the minimal area of hyperemia about the membrane, and by the fact that the membrane actually extended to areas beyond the tonsil—The manner of curling at the edges, the membrane remaining adherent over a tiny area, was indicative of a Klebs-Loeffler infection—The faded hemorrhagic spots present in this membrane were also a factor in helping to determine the nature of the disease

There are some points that aid in the clinical appraisal of a membranous lesion of the oropharynx that have not been heretofore suggested

- 1 A limited and fairly well-demarcated area of hyperemia about the membrane and an absence of extensive inflammatory reaction, especially early in the disease, is indicative of diphtheria
- 2 A membrane or exudate which seems to have extended since previous examinations is presumptive evidence of diphtheria
- 3 Diphtheria is a strong possibility if the exudate or membrane extends above the faucial pillars

- 4 When the uvula is involved in addition to the tonsillar areas, then diphtheritic infection is almost certain
- 5 Edema of the soft palate exists with only a small amount of surrounding inflammation when the lesion is due to C diphtheriae. In most cases due to pyogenic micro-organisms a distinct redness of the mucous membranes is noted. In neglecting this point, many diptheritic infections with edema of the surrounding tissues have been called peritonsillar abscesses. The hazard of such mistakes has been reviewed.

Other helpful and well-established factors are tone appearance, presence of albuminums in 30 to 40 per cent of severe cases, rapid, soft, compressible pulse out of proportion to the fever, and a rhinorrhea which may be blood-tinged

Some of the misconceptions that interfere with

correct diagnosis are here listed

1 The common belief that pain is not a prominent feature of diphtheria cannot be substantiated. In this case and many other adult patients, pain is cherted as a complaint, especially when edema of the soft parts is present. This becomes more evident when secondary invaders are present in sufficient numbers.

2 The idea that low temperatures are characteristic of diphtheritic infections sometimes can be misleading. In uncomplicated diphtheria, low temperatures do exist. However, whenever adenocellulitis or a mixed infection is present, elevated temperatures are common. Moreover, with this rise in temperature, the pulse-temperature ratio principle no longer holds true.

3 The characteristic musty odor usually associated with diphtheria is not always present Morgover, the characteristically described odor may be present in other necrotizing lesion of the pharynx.

4 Dr Drinkwater<sup>11</sup> has emphasized that the existence of only one patch occurring in each tonsillar, palatine, and uvular area is pathognomomic of C diphtheriae infection. However, this has not been the experience of observers at the Willard Parker Hospital and elsewhere, who have found several patches of diphtheritic infections beginning in these areas. Some diphtheritic infections beginning in the follicular crypts simulating follicular tonsillitis. It is interesting to note that these patients, on te-examination twenty-four to thirty-six hours later, may show coalescence of these follicles to give a membrane

At the risk of repetition, <sup>12-15</sup> it may be of value to emphasize that the preliminary cultures taken from the nose and throat have been shown frequently not to contain C diphtheriae. There have been various reasons given for this. In taking cultures, the physician often does not dig deeply enough under the membranes and only the surface is cultured. When rapid culture methods are used, experience in recognizing the early forms of diphtheritic micro-organisms is essential, as often these

forms may not be identified. Frequent cultural examinations are necessary and only after cultures taken at forty-eight-hour intervals are returned with perative reports is the patient considered nondiphtheric.

It is generally accepted that diphtheria can occur occasionally in Schick-negative patients 16 How ever it is also agreed that seven complications are unusual<sup>17</sup> in these patients. With this in mind we fail to understand why the armed forces do not require a Schick test upon all inducted This neg lect seems particularly regrettable since it is known that the Schick test will act as a booster dose to those previously inoculated 4 A 24-year-old Shick positive veteran who was admitted to Willard Parker Hospital one week after discharge from the Army with faucial diphtheria, died five weeks later with a severe myocarditis. In view of these facts it would seem advisable to have Shick tests done routinely on Army personnel

- An unusual case of faucial membranous diphtherla with extreme brady cardia 10 to 11 per min-
- ute, is presented. The criteria which may aid in making a pre-
- sumptive clinical diagnosis are discussed Attention was called to certain prevalent misconcuptions about diphtheria.

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#### NOTE

Electrocardiographi examinations were made through the courtery of Dr Edward A Burkhardt

Laboratory examinations were carried out by Miss Naney Nemer and Miss Gladys Haber

Mrs Lillian Buxbaum gave invaluable help in formulating the paper

#### BREASTS AND BRASSIERES

Commercial interests, obsessed by sexual fetishism centering around the mammary glands are overemphasizing their product At the same time they are not responsible for the original emphasis on the breasts in our time, for that started with the tight Hollywood sweater inspired no doubt, by some crotic male. The sweater however was not good enough for the purpose since the breasts themselves were not usually sensational, so now the designers artists, exploiters of feshions, and manu facturers have given us a synthetic something that proclaims beguiningly to all bemused lechers 'Here I come don't look now

'Beguilingly' is the word, for these contraptions are intended to deceive the naive male. Beneath their phony opulence and aggression lie the undeveloped organs whose biologic destiny has been thwarted by our civilization, along with all the other deficiencies so evident in our many under

sexed women-pallid lips and roseless cheeks (under the lipstick, rouge, and kalsomine) frigidity, sterility dysmonorrhea, endometriosis, pelvic pa thology incident to the congestion that regularly accompanies inability to experience unfrustrated intercourse, dystocia, etc. Of course the baby seeking nourishment at the and breast might as well suckle the brassitre And so artificial feeding becomes logical enough in a civilization decadent at so many points.

Those charged with the writing of the trade s advertising blah are clever poets of the mammary school, we should call them

In fairness though we have to admit that our numerous woird sisters have their counterparts increasingly evident among the decadent males of the world, whose degeneracies have been accurately recorded by Conkin of Princeton University —

Medical Times May 1947

#### MASSIVE BILATERAL FIBROMAS OF THE OVARIES ASSOCIATED WITH ASCITES AND HYDROTHORAX MEIGS' SYNDROME

WILLIAM J FUSARO, M D, Brooklyn, New York

(From the Norwegian Hospital)

FIBROMA of the ovary associated with ascites and hydrothorax is a definite clinical syndrome The dramatic permanent disappearance of the chest and abdominal fluid following removal of the tumors has been demonstrated repeatedly in the for this condition to be kept in mind because of its resemblance to the picture of intra-abdominal malignancy with metastatic involvement of the Every effort for a correct diagnosis should be made, even to the extent of an exploratory laparotomy in an apparently doomed patient physical suffering from repeated chest and abdominal paracentesis, deep x-ray therapy, and other procedures can be avoided, not to mention the mental anxiety and torture not only to the patient but to the family as well

Meigs, although not the first to report this condition, has done more than anyone else to stimulate our interest and encourage correct diagnosis, directing our attention to the absolute surgical cure that can be accomplished by one of the simplest of

laparotomies

#### Case Report

A S, a 24-year-old white, single woman, was admitted to the Norwegian Hospital on August 17, 1943, with the chief complaint of pain in left lower quadrant and swelling of abdomen. History of present illness was that for several weeks the patient had experienced pain in the lower abdomen more marked on the left side and with a tendency to be-come worse at night — The pain was associated now and then with nausea, but no vomiting domen had become progressively larger and there was an increasing sensation of heaviness had no menstruction for the past two months There were no other associated symptoms history was noncontributory and family history was likewise negative Physical examination revealed a young, adult, white women in apparently no distress, having a temperature of 100 F, pulse, 110, respiration, 22, and blood pressure, 124/74 The chest revealed flatness in right base with distant to no breath sounds audible. The abdomen was moderately uniformly enlarged, especially below the umbilicus It was uniformly tense and a large resistant mass was palpable in both lower quadrants, extending into the left flank anteriorly. The left side was decidedly tender On percussion an area of dullness from the pubis, extending upward with an arch-like distribution, reaching the flanks laterally and the umbilicus in midline, was mapped A fluid wave was also elicited Impression on admission was ovarian cyst, fibroid uterus, ascites, and pleural effusion

An x-ray revealed fluid in the lower third of the est. This was tapped and 510 cc. of pale, strawcolored fluid, having a specific gravity of 1 025, and alkaline in reaction, was recovered. The cell count was infinite, the albumin, a heavy cloud. the smear was negative for organisms, bile, negative.

and culture, negative

The blood count revealed 4,200,000 red blood cells, with a hemoglobin of 85 per cent Sahli, a white blood count of 12,800, with 92 per cent polymorphonuclears, 7 per cent lymphocytes, and 1 per cent cosmophils Urinalysis was negative

Her general condition improved with rest in bed, the pain and abdominal discomfort being much However, fluid in the chest increased daily

following a tap on August 18 On August 20 it was decided we were dealing with a Meigs' syndrome, but operation was deferred because of cough and temperature The patient was given sulfadiazine and terpene hydrate August 25 an x-ray revealed the fluid level to have reached the level of the third rib anteriorly second tapping of the chest was done following v-ray, the fluid being of the same character as that previously recovered and in the amount of 550 cc

Breathing became easier for a few days, but temperature persisted between 99 F and 100 F. On August 29 after clinically observing an increase in the chest fluid again, although a temperature of 99 F to 100 F still persisted, an operation was decided upon The patient was prepared for operation and on August 30, under spinal anesthesia of 100 mg of novocaine and 15 mg of pontocaine, a laparotomy was performed and bilateral massive fibromas of the ovaries were removed. The right tumor filled the pelvis and extended up, occupying the right side of the abdomen as well. The left tumor was entirely outside of the pelvis and occupied the left side of the abdomen Peritoneal fluid was abundant, filling the entire cavity The uterus was normal. The tubes were markedly distorted but not the seat of any pathology Stomach, liver, intestines, and gallbladder were found free of pathology Palpation of retroperitoneum also was negative

Pathologic Report —Gross Examination specimen consists of two large oval masses of moderately firm tissue One measured 6 by 5 by 3 inches and weighed 4 pounds, the other measured 10 by 5 by 3 inches and weighed 5 pounds each there was an area of roughness where they were detached There were numerous rounded pronections on the surface On section, masses presented white and yellow tissue in cords and whorls There was one area which was softer and pinkish

in color, and appeared broken down

Microscopic Examination This revealed dense fibrous tissue, arranged in cords and whorls There were some areas of faintly staining fibroblasts There was a thick fibrous tissue capsule along one Some sections showed fibrous tissue of looser construction and there were areas that appeared to be areolar tissue with large cystic spaces were sections which showed ovarian tissue of dense construction, apparently in a compressed state

The pathologic diagnosis was bilateral fibromas of ovaries

The patient made an uneventful recovery from the operation. The wound healed by primary union and she was discharged September 10 1943, cloven days after operation On September 9 x ray of the chest revealed the fluid had dropped to the level of the fifth rib This gradually diminished until on October 22 1943 the fluid had entirely disappeared. She progressed favorably at home gaining weight, and tecling better all the time

However, on December 6 1913 aho began to notice a weakness of her legs which progressed within one week to actual paralysis. She was hospitalized on December 13, 1943, and x ray study revealed complete collapse of the body of the ninth dorsal vertebra and 50 per cent collapse of the body of the other than the body of the other than the body of the other than the pelvis and upper part of left femur. She was discharged in four days and fatal prognosis was given to the family

She expired a few weeks later at home During these several weeks I saw her frequently and at no time was I able to find signs of recurrence of fluid in the chest or abdomen The family was very much disturbed and refused not only autopay but further study for primary lesion at the time of second admission to the hospital.

#### Comment

My first thought was that the primary site of the metastasis might have been the ovaries and we missed the microscopic diagnosis. However repeated study of the sildes by the pathologist and other pathologists left us no diagnosis but simple

fibroma as far as the ovaries were concerned

The pathology apparently was so definite and the postoperative course so typical that I am certain the ovarian tumors had nothing to do with the

lesions in the bone She could have had a 'silent' malignancy elsewhere giving rise to the metastasss.

At operation there was no evidence of malignancy in the peritoneal cavity or retroperstoneal space. If the fluid in the chest had been of malignant origin It would not have disappeared following removal of the tumors, the way it did, never to return. The same holds true of the ascitle fluid. When the patient was tapped prior to operation on two occasions, the fluid rapidly recurred in a few days a fact peculiar in this syndrome, as compared to a slow recurrence of fluid in malignance.

I am thoroughly convinced this was a case of Meigs syndrome and that a silent malignancy was coexistent but played no part in the formation of the

peritoneal and pleural effusions

In a personal communication Dr Joe V Meigs stated that this seemed to be a case of true syndrome of fibroma of the ovary associated with fluid in the chest and fluid in the abdomen. He had not seen tumors of this size in his experience. It appeared from the description that they were simple fibromas with areas of pecrosis in them.

Where the metastasis came from was a very difficult question to answer Dr Meigs believed that she probably had a carcinoma of the breast or some other site. It could have been so small as to have been overlooked. It was possible that a lesion in the vertebra might have been missed but he thought that it was very unlikely that this tumor which is predominantly a fibronia, could metasta size in that way.

#### AVIATION MEDICINE COURSE ANNOUNCED

The recall of 20 Medical Corps Reserve officers annually for a period of ninety days, for the purpose of attending a course of instruction and training in Aviation Medicine, was recently announced by the War Department.

The course of instruction which is being presented under the technical supervision of the Air Burgeon at the AAF School of Aviation Medicine, Randolph Field, Texas covers a study of the fundamentals of Aviation Medicine with a special emphasis placed on the principles and practice of medicine as applied to aviation and the efficient performance of the <sup>16</sup>4 Physical Examination for Flying. Each graduate will receive a certificate designating him an Aviation Medical Examine.

Eligibility for the course requires the applicant to be under 40 years of age, meet minimum physical requirements for flying, and have an efficiency index

of 40 or above and not currently designated a Flight Surgeon or Aviation Modical Examiner. He must possess a real interest in avaition medicine and a desire to become an Aviation Medical Examiner. The physical examination may be obtained at most Army Air Force stations or an examination by any Flight Surgeon or Aviation Medical Examiner is acceptable.

The first class will begin October 6 and extend through December 12, 1947 Government quarters will be available at Randolph Field for students enrolled in the course Facilities will not permit

quarters for dependents.

Applications for this training should be made by letter accompanied by a copy of the WD AGO 69 Physical Examination for Flying to the Office of The Surgeon General, Attention Military Personnel Division by not later than August 16 1047

## LEPROSY TREATED WITH PENICILLIN

RAPHAEL LANDAU, M D, New York City

(From the Willard Parker Hospital, New York)

ALTHOUGH leprosy has been known since antiquity, up to the present no satisfactory treatment for the disease has been found. Various oral and parenteral remedies have been tried, such as chaulmoogra oil, gold salts, and diphtheria toxoid, without much effect. The drugs most recently tried are promin (a sulfonamide) and penicillin. Promin promotes healing of the nasal, laryngeal, and oral lesions, it is quite toxic, however, causing headaches, allergic rhinitis, acute leprous reaction, and hemolytic complications.

Penicillin was first tried in leprosy in 1945 by Faget and Pogge<sup>1</sup> in Carville, Louisana gave intramuscular injections of 50,000 to 300,000 units daily, over periods varying from four days to one month No beneficial effect was noted during the treatment or for six months thereafter reaction (chills, fever, nausea, erythema nodosum, and muscular pain) was observed in 1 patient who was treated during a subacute leprous reaction More favorable results were reported by Wharton<sup>2</sup> in British Guiana. In his report to the Board of Penicillin Control he states that, while penicillin does not exert a bactericidal or bacteriostatic action on the leprosy bacillus, it is of definite value in the complications of the disease, especially ulcerating nodules, lepra reaction, chronic ulcers, and inflammatory conditions of the eyes He concluded that the marked improvement in the physical and mental condition in far advanced cases would justify its use. His patients received a total of 100,000 to 400,000 units of the sodium salt of penicillin, given in 5,000 to 10,000 unit doses, every three hours intramuscularly

We wish to report a case of leprosy treated with penicilin at the Willard Parker Hospital. The treatment was started on a purely empiric basis before any reports on penicilin therapy for leprosy had appeared in the literature. The sodium salt of penicilin was not available at the time, and the patient was therefore treated with crude penicilin, prepared in the laboratory of Willard Parker Hospital. Later a small amount of penicilin X was obtained through the courtesy of Lederle Laboratories, Inc. Penicillin X was given for only four days.

### Case Report

The patient was a Puerto Rican man, 18 years old, who had been in the United States for six months Past history was noncontributory. There were no

cases of leprosy in the family

Physical Examination—The patient, when admitted to the Willard Parker Hospital, was a well-developed, well-nourished, light-skinned man—The temperature, pulse rate, and respirations were normal—The carlobes and the outer outlines of the cars were markedly enlarged, fleshy, nodular, and brownish in color, a small weeping cracked area was present on the upper lip—Pea-sized, nontender,

movable nodules were visible in chains on the outer surface of the arms, forcarms, and over the tibiac. Dark red, crusted areas of ulcerations, I to 2 cm in diameter, were present over both clows and the left forcarm, small pulpable nontender cervical, epitrochlear and inguinal nodes were present. No area of anesthesia could be found. The mucous membrane of the nose was covered with dried bloody crusts, but no perforation of the septum could be seen. The rest of the physical findings were normal

Laboratory Data — Smears from the nasal mucosa and scrapings of the crusts from both elbows were positive for acid-fast bacilli. Nasal smears remained positive throughout the course. The Wassermann reaction was four plus. Biopsics from several cutaneous lesions showed typical lesions of leprosy with numerous foam cells and acid-fast bacilli, best demonstrated in slides stained by the Fite method. Urine was normal. Blood count on October 26, 1944, was red blood cells, 4,900,000, 83 per cent hemoglobin. White blood count was 10,600, with 57 per cent neutrophils, 31 per cent lymphocytes, 4 per cent monocy tes, and 13 per cent eosinophils. Sedimentation rate fluctuated between 13 and 32 per hour. (Cutler method The high figure was obtained during an attack of situstis.) Stool examination revealed no over or parasites.

Therapy—The patient received 3,225,900 units of crude penicilin within six months 3,029,900 units were given intramuscularly, and 177,500 units were injected partly into the nodule of the left elbow and partly by infiltration into the surrounding subcutaneous tissue. When the infiltration route was used on the left forearm, a similar amount of the liquid medium<sup>3</sup> used for the production of the penicillin was injected as a control into two nodules on the right upper arm The local injections were discontinued after seven days because one of the crusted lesions over the left elbow showed superficial infection with hemolytic streptococcus Intramuscular administration was started on November 9. 1944, and was given for the following seven months The patient received (in a single injection) between 1,000 and 300,000 units of penicillin in the glutcal regions daily, except for short interruptions of treatment when penicillin was not available intravenous route was tried in addition to the intramuscular on December 21, 1944, 177,500 units were given in six hours. In addition a total of 337,000 units of penicillin X was given intramuscularly for four days

Course of the Disease—There was a slow subsidence of all nodules. The edema of the face, wrists, and ankles disappeared completely after nine weeks. The intravenous route was discontinued because of fever, but the intramuscular administration of crude penicillin was continued.

The percentage of cosmophils began to increase soon after beginning of the treatment, rising from 13 to 32 per cent within five weeks. The cosmophila declined, reaching the original figure of 13 per cent after five months of treatment. When pencillin was discontinued the percentage of cosmophils dropped to 5 per cent.

There was a degree of correlation between the

cosmophilia of the blood and local changes in the leprous lesions In twelve to thirty-six hours after a temporary rise in the percentage of cosinophils, the skin over the nodules were found to be flatter and softer than before and in five to six days the nod ules became either nonpalpable or markedly smaller The percentage of cosmophils tenually went down two or three points at that time

After four months of treatment all ulcors were Many old nodules in various parts of hoaled. the body disappeared all became flattened number of nodules were no longer palpable Vimble old nodules were still present on the back of the left hand, on the upper left arm, on the distal end of the left tible, anteriorly, and close to the Achilles tendon of the left leg. The larger nodules of the clows practically disappeared The lesion of the lip healed, the car lobes became flatter. All remaining nodules decreased in size and continued to decrease in size as noted upon physical examination four months after treatment was discontinued.

Biopsies -The histologic appearance of biopsies taken from the nodules before and during the treatment revealed typical leprous lesions, with add fast bacilli and foam cells present. Biopsy after treatment revealed the character of the lesions to be the same although the bacilli were less numerous and many of them were beaded. Some cosinophils were present around the lesions After nine months of treatment a fibroblastic reaction was seen in the upper levels of the corium near the granulomatous

legions.

#### Discussion

The patient showed a favorable chinical response to the treatment with crude penicillin. All ulcors healed, some nodules disappeared and a number of nodules became flat

It is difficult to state whether this was a specific

curative effect of penicillin or whether it was a nonspecific action as a result of inflammatory reanonse of leprous lesions to injections of a foreign substance. A slow but gradual improvement was observed after the reaction to each injection of penicilin When the reaction subsided, the cosmophils in the blood became less numerous suggests the possibility that the reaction was allergic in nature, with subsequent desensitization of the patient There was no appreciable change in the sedimentation rate during or after the treatment

#### Summary

A patient with leprosy was treated parenter ally over a period of six months with crude penicillin. Some clinical improvement with healing of ulcers and disappearance of nodules was noted after four The improvement followed months of treatment slight erythematous reaction of the skin over the nodules following each injection of penicillin

No general reactions were noted following intramuscular administration of crude penicillin. Intravenous injection produced a rise of tempera-

ture to 104 5 F

No significant changes in histologic structure of the persisting nodules were observed.

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Nore I wish to thank Dr D M Tolle Dr J Rosenbluth Dr V Dolgopol and Mrs L Buxbaum for their kind assist ance in making this study possible.

THE NEW YORK ACADEMY OF MEDICINE ANNOUNCES THE CREATION OF A SECTION ON MICROBIOLOGY

At a recent meeting of The New York Academy of Medicine the Fellowship of the Academy voted approval of the organization of a Section on Microbiology This action followed a request submitted to the Council of the Academy by a group of experts in the field of microbiology

This Section on Microbiology which is the twelfth of the Sections of the Academy has for its main objectives the encouragement of the exchange of information among microbiologists and the promotion of ready contacts between clinical and laboratory in-

vestigators The Fellowship of the Section will be broad, and will include not only those who have a direct interest in microbiology but also those who deal with microbiology in their primary functions as clinicians or scientists in other branches.

The officers of the newly organized Section are chairman, Gregory Shwarisman, M.D. secretary Hurry Most, M.D. advisory committee, Road J Dubos, M.D. Frank I. Horsfall Jr., M.D. Colin M. MacLeod, M.D., Raiph S. Muckenfuss, M.D., and John G. Kidd, M.D.

# DEPARTMENT OF MEDICAL CARE INSURANCE

CONDUCTED BY GEORGE P FARRELL, DIRECTOR

## Progress of New York State Voluntary Nonprofit Medical Care Plans

(Approved by the Medical Society of the State of New York)

THE graph below illustrates the steady and phenomenal growth of New York State medical care plans from 1940 to December 31, 1946 During 1946 membership (subscriber and dependents) in the six voluntary medical care plans increased by 329-794, making a total membership of 598,042, or an increase of 122 per

75,000

25,000

15,000

5,000

cent as of December 600,000 31, 1946 The continued increase in enrollment since January 1, 1947, of 177,000 new 300,000 members is a definite indication of the acceptance by the public 150,000 of benefits offered by the plans Enrollment as of May 31, 1947, totaled 775,000 members

During 1946 physicians submitted over 95,000 claims on behalf of members, in ex-\$2,000,000 cess of This represents benefits to members equivalent to one million office calls at \$200, twenty thousand appendectomies at \$100, or fifty thousand tonsillectomies at \$40

Two new plans were organized in 1946 The GeneseeValley Medical

Care, Inc , Rochester, New York, offering a surgical indemnity contract, and the Northeastern New York Medical Service, Inc , Albany, offering a surgical and inhospital medical service contract to individual members with incomes less than \$2,000 annually. and the family subscriber whose income does not exceed \$3,500 annually

In 1946 all plans agreed to accept a member by transfer from another plan and allow credits accrued under the original contract for waiting periods toward all limitations under new contract to

Subscribers may apply for any type of be issued contract currently offered and the plan will accept a subscriber from an out-of-state plan which recipro-Waiting periods for maternity benefits will be credited from date of original contract on transferred members, provided the original contract

\$2,000,000

\$1,000,000

250,000

offered this service The Genesce Valley Medical Care plan reserves the right to reject or make an exception for any physical condition which existed at the time of enroll-\$ 500,000 ment in the original plan This agreement among nonprofit volun tary plans in the State is a definite advantage to its 775,000 members in having the guarantee of continued membership and protection without penalties

> Due to the successful record of United 10,000 Medical Service, New York City, effective January 1, 1947, benefits were increased substantially in the surgical contract allowances and service benefits provided for all indemnity contract holdsubscription rates

\$ 150,000 100,000 1945 - BENEFITS TO MEMBERS ers at no increase in

It is anticipated that membership will increase to one million and benefits exceed three and a half million dollars during 1947, with all plans in full operation

With over 16,000 participating physicians this objective can be accomplished by their continued cooperation in acquainting patients with the benefits provided under the plans to the mutual advantage of physician and patient

#### HISTORY OF FOODS

It was Queen Elizabeth who started the custom of eating three meals a day in the British Isles Prior to her reign, the Englishman was satisfied with only two -Food and Nutration, April, 1947

## NECROLOGY

Oscar L Baumann, M D, 59, of New York City died on May 17 He received his medical degree in 1910 from the College of Physicians and Surgeons, Columbia University Dr Baumann was a member of the State and County medical societies, and

the American Medical Association.

Gertrude Behrens, M.D., of New York City, died on May 20 She was a graduate of the Uni versity of Kiel, Germany, in the class of 1919 She was attending physician of the obstetrical department of the New York Infirmary for Women and Children New York City and visiting clinical assistant of the Bellovue Pediatric Department, Bellevue Hospital. Dr Behrens was a number of the State and County medical societies, American Medical Association and the Women's Medical Society She was 53 years of age at the time of her death.

J Bayard Clark, M.D , 73 of New York City died on May 20 He was formerly professor of urology at New York Polyclinic Medical School and a genitourinary surgeon for many years in various city

hospitals.

Dr Clark received his medical degree in 1898 from the College of Physicians and Surgeons Columbia University He was a member of the American Association of Genito-Urinary Surgeons the American Urological Society, the International Surgical Society the New York Academy of Medi-cine the American Medical Association, and the

State and County medical societies

Harold Sparrow Dorrance, M D , 55 of Rochester died on May 21 He received his medical degree in 1920 from the Harvard Medical School He was senior attending physician to Highland Hospital of Rochester Dr Dorrance was a member of the American Medical Association, and the State and County medical societies.

Country medical societies.

Clile Hirschfield, M.D., 60 of New York City died on May 26 She was graduated from the College of Physicians and Surgeons in Boston, Massachusetts, in 1901. She was a member of the Amarican Medical Association and the State and Country.

County medical societies

Frank B Keleher, M.D 73, of Brooklyn, died on April 18. Dr Keleher was assistant pediatri cian at St. Mary's Hospital, Brooklyn. He was graduated from Long Island College of Medicine in 1895 and was a former member of the Kinga County Medical Society the Brooklyn Medical Society and the Catholic Physicians Gulld

Harold C Lyman, M D, of Utics, medical di rector of Memorial Hospital for twenty-three years and a director of the State Society of Industrial Medicine died on May 20 His ago was 54 He received his medical degree in 1917 from the New

York Medical College Flower and Fifth Avenue Hospitals He was a member of the American Institute of Homeopathy and the State Homeo-

Pathic Society
Charles J Mengis, M.D., 72 of Buffalo died
April 27 He was graduated from Niagara Univer sity Medical School in 1890 Dr Mengis was attending physician at the Shelter Home of the Erle County Welfare Department for about five years and resigned in 1940 He was a member of the Buffalo Academy of Medicine, the American

Medical Association, and a former member of the Eric County Medical Society Francis Mulcare, M.D., of Schenectady died on April 18 1946 He was graduated from the Albany Medical College in 1924 Dr. Mulcare was a mem ber of the American Medical Association, and the State and County medical societies At the time

of his death he was 49 years old.

Albert Grove Odell, M.D., of Clifton Springs, a member of the Clifton Springs Sanatorium staff for thirty four years died on May 19 Dr Odell was graduated from Syracuse University College of Medicine, in 1904 and was a member of the Ameri can Psychiatric Society the American Association for the Study of Montal Deficiency, the American Medical Association, and the State and County medical societies He was consulting psychiatrist at the Newark (New York) State School Dr Odell was 69 at the time of his death.

Albert A. Ripperger, M D, 85 of New York City died on May 21 He studied medicine at the Uni-versity of Munich and received his degree in 1893 Dr. Ripperger was associated with the German Hospital and Dispensary New York City which is now the Lenox Hill Hospital where he developed the Ripperger shield a lead apron to protect opera-

tors from x ray burns

Charles Edward Scofield M.D., of Brooklyn died on May 18 at the age of 70 Dr Scofield was president of the Kings County Medical Society in 1923, and was senior surgeon of the Brooklyn Lye and Car Hospital and an attending specialist to St Glies Hospital. He received his medical degree in 1890 from the College of Physicians and Surgeons Columbia University He was a member of the American College of Surgeons the American Medical Association, and the State and County medical societies

Joseph Yale Spinuxza, M.D., 48 of Buffalo died on April 21 He was graduated in 1925 from the University of Buffalo School of Medicine, and was assistant surgeon at Lafayette General Hospi tal, Buffalo He was a member of the American Medical Association, and the State and County

medical societies.

#### ENGLISH PHYSICIAN RECEIVES GASTROENTEROLOGY AWARD

The National Gastroenterological Association has announced that First Prize in its 1947 Prize Award Contest for the best unpublished contribution on gastroenterology or an allied subject has been awarded to Dr Frederic Duran-Jorda, of Manchester, England.

Dr Duran-Jorda s paper on Histo-Pathology of the Semi-Squamous Epithelial Layer as Found in the Colon was selected by the judges from among twelve entries received from all parts of the world.

The check for \$100 representing the first prize and a Certificate of Merit were awarded at the Annual

Banquet in Atlantic City, N J on June 5
Certificates of Merit also were awarded to Dra
William Nimeh, of Mesneo City D F, August
Schrumpf and Trygro Kahrs, of Porsgrunn, Norway
W\_Paolino and G Boccussi, of Turin, Italy

The winning paper as well as those receiving Cer tificates of Merit will be published in the Review of

Gastroenterology

## WOMAN'S AUXILIARY

## TO THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

Officers of Standing Committees Appointed for 1947-1948

CHAIRMEN of standing committees for 1947-1948 for the Woman's Auxiliary to the Medical Society of the State of New York have been appointed by Mrs Harry F Pohlmann, president

They are finance committee, Mrs Bradford F Golly, of Rome, convention, Mrs Clifton L Dance, of Brooklyn, press and publicity, Mrs Lee R Sanborn, of Angola, national bulletin, Mrs William J Godfrey, of Flushing, legislation, Mrs Alfred S Grussner, of Schenectady, Physicians' Home, Mrs

George P Bergman, of Mattituck, Long Island historian, Mrs Arthur F Holding, of Albany, archives, Mrs Thomas M D'Angelo, of Flushing, organization, Mrs Herman W Galster, of Scotia, printing and supplies, Mrs Hugh G Henry, of Germantown, public relations, Mrs Walter G Hayward, of Jamestown, parliamentarian, Mrs Gerald C Cooney of Syracuse, program, Mrs August Fincke, of Garden City, and Hygeia, Mrs Joseph Elia, of Niagara Falls

## County News

Erie County The monthly luncheon meeting of the Woman's Auxiliary to the Erie County Medical Society was held May 27 at the Hotel Statler in Buffalo Thomas Cook Brown, chief editorial writer of the Buffalo Courier-Express, spoke on "The United Nations" Reports on the State Auxiliary Convention were given by Mrs Ralph Upson, president-elect and chairman of delegates for Erie County

The Auxiliary voted to increase the amount of their Voluntary Loan Scholarship Fund for student nurses and to offer two full scholarships this year Hostesses for the meeting were Mrs J W, Bayliss, Mrs Thomas G Allen, Mrs Joseph S Tunnel, Mrs Fred G Carl, and Mrs Harold G Reist

Saratoga County A luncheon meeting of the Woman's Auxiliary to the Saratoga County Medical Society was held June 3 in the Schuyler House, Mechanicville A report on the State Auxiliary Convention, held in Buffalo in May, was given by Mrs Thomas E Bullard, first vice-president of the State Auxiliary A donation was made for the Cancer Fund

## **ANNOUNCEMENT**

THE UNIVERSITY OF THE STATE OF NEW YORK THE STATE EDUCATIONAL DEPARTMENT BOARD OF MEDICAL EXAMINERS

Dr W P Anderton, Secretary Medical Society of the State of New York 292 Madison. Avenue New York 17, N Y Dear Dr Anderton

This is to certify that the Board of Regents at a meeting held April 18, 1947,

VOTED, That the determination of the medical Committee on Grievances in the matter of the application for the revocation of the medical license heretofore granted to Carl Joseph Sachs, Brooklyn, be accepted and sustained, that, in compliance with the recommendation of said committee, said Carl Joseph Sachs be censured and reprimanded, that said Carl Joseph Sachs be ordered to appear for such censure and reprimand before the Board of Regents at a time and

place to be determined by the Commissioner of Education, notice of which shall be given to said Carl Joseph Sachs by said Commissioner, and that the Commissioner of Education be empowered and directed to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote

Dr Carl Joseph Sachs is registered for the year 1947 to 1948 from 1138 Eastern Parkway, Brooklyn, New York. The order was served on Dr Sachs on May 1, 1947

Sincerely yours,

(Signed) JACOB L LOCHNER, JR, MD, Secretary NY State Board of Medical Examiners

May 13, 1947



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## **BOOKS**

Books for review should be sent to the Book Review Department at 1313 Bedford Avenue Brooklyn N Y Acknowledgment of receipt will be made in these columns and deemed sufficient notification Selection for review will be based on merit and interest to our readers

#### RECEIVED

Medicine in the Changing Order Report of the New York Academy of Medicine Committee on Medicine and the Changing Order, Malcolm Goodridge, M D, Chairman Octavo of 240 pages New York, Commonwealth Fund, 1947 Cloth, \$2.00

Radical Surgery in Advanced Abdominal Cancer By Alexander Brunschwig, M D Octavo of 324 pages, illustrated Chicago, University of Chicago Press, 1947 Cloth \$7 50

Monocular Vision Training By Mildred Smith Evans Quarto of 93 pages, illustrated Baltimore, Williams & Wilkins Company, 1947 Cloth, \$3 00

Radiology for Medical Students By Fred Jenner Hodges, M D Isadore Lampe, M D, and John Floyd Holt, M D Octavo of 424 pages, illustrated Chicago, Year Book Publishers, 1947 Cloth, S6 75

War Stress and Neurotic Illness By Abram Kardiner, M D with the collaboration of Herbert Spiegel, M D Second Edition of The Traumatic Neuroscs of War Octavo of 428 pages New York, Paul B Hoeber, Inc., 1947 Cloth, \$4.50

Penicilin in Syphilis By Joseph Earle Moore, M D Octavo of 319 pages, illustrated Springfield, Ill, Charles C Thomas, 1946 Cloth, \$5.00

Practical Physiological Chemistry By Philip B Hawk, Ph D, Bernard L Oser, Ph D, and William H Summerson, Ph D Twelfth Edition Octavo of 1,323 pages, illustrated Philadelphia, Blakiston Company, 1947

Handbook of Physiology & Biochemistry Originally "Kirkes" and Later "Halliburton's" By R J S McDowall, M D Thirty-Ninth Edition Large Duodecimo of 898 pages, illustrated Philadelphia, Blakiston Company, 1946 Cloth, 87 00

Functional Cardiovascular Disease By Lt Col Meyer Friedman, USMR Octavo of 266 pages Baltimore Williams & Wilkins Company, 1947 Cloth, \$3 00

Diagnostic Examination of the Eye Step-by-Step Procedure By Conrad Berens, M D, and Joshua Zuckerman, M D Octavo of 711 pages, illustrated Philadelphia, J B Lippincott, 1946 Cloth, \$15

The Philosophy of Insanity By a late inmate of the Glasgow Royal Asylum for lunatics at Gartnavel Large duodecimo of 116 pages New York, Greenberg Publisher, 1947 Cloth, \$250

Fundamentals of Clinical Neurology By H Houston Merritt, M D, Fred A Mettler, M D, and Tracy Jackson Putnam, M D Octavo of 289 pages, illustrated Philadelphia Blakiston Company, 1947 Cloth, \$6 00 Principles and Practice of Obstetrics By Joseph B De Lee, M D, and J P Greenhill, M D Ninth Edition Large Octavo of 1,011 pages, illustrated Philadelphia, W B Saunders Company, 1947 Cloth, \$10

X-Ray Diffraction Studies in Biology and Medicine By Mona Spiegel-Adolf, M D, and George C Henny, M D Octavo of 215 pages, illustrated New York, Grune & Stratton, 1947 Cloth, \$5 50

The Peripheral Circulation in Health and Disease A Study in Clinical Science By Robert L Richards, M D Octavo of 153 pages, illustrated Baltimore, Williams & Wilkins Company, 1946 Cloth, \$6 00

Sugars and Sugar Derivatives in Pharmacy By Paul S Pittenger, Phar D Octavo of 53 pages, illustrated New York, Sugar Research Foundation, 1947

Concise Chemical and Technical Dictionary Edited by H Bennett Octavo of 1,055 pages Brooklyn, Chemical Publishing Co, 1947 Cloth, \$10

The Practice of Physical Medicine By Heinrich F Wolf, M D Octavo of 322 pages, illustrated Chicago, Wilcox & Follett Co, 1947 Cloth, \$500

Experiences with Folic Acid By Tom D Spies, M D Octavo of 110 pages, illustrated Chicago, Year Book Publishers, 1947 Cloth, \$3 75

Aphasia A Guide to Retraining By Capt Louis Granich, MC, USA Appendix in collaboration with Sgt George W Pangle, MC, USA 108 pages New York, Grune & Stratton, 1947 Cloth, \$2.75

Synopsis of Operative Surgery By H E Mobley, M D Second Edition Duodecimo of 416 pages, illustrated St Louis, C V Mosby Company, 1947 Cloth, \$6 00

Uterotubal Insufflation A Clinical Diagnostic Method of Determining the Tubal Factor in Sterility Including Therapeutic Aspects and Comparative Notes on Hysterosalpingography By I C Rubin, M D Octavo of 453 pages, illustrated St Louis, C V Mosby Company, 1947 Cloth, \$10

The Head, Neck, and Trunk Muscles and Motor Points By Daniel P Quiring, Ph D Octavo of 115 pages, illustrated Philadelphia, Lea & Febiger, 1947 Cloth, \$2.75

Gynaecological Endocrinology For the Practitioner By P M F Bishop, D M (Ovon) Duodecimo of 124 pages, illustrated Baltimore, Williams & Wilkins Company, 1946 Cloth, \$200

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[Continued from page 1522]

#### REVIEWED

X-Rays and Radium in the Treatment of Diseases of The Skin By George M MacKee, MD, and Anthony C Cipollaro, MD Contributor, Hamilton Montgomery, MD Fourth edition Octavo of 668 pages, illustrated Philadelphia, Lea & Febiger, 1946 Cloth, \$10

This is a fourth edition of a textbook whose popularity has never waned since its first appearance. Conceived and written by one of the foremost teachers in his profession, Doctor McKee speaks with authority on a subject in which his vast knowledge and experience has brought him

pre-eminence

To the dermatologist and those technicians concerned with the use of  $\lambda$ -rays and radium in the treatment of skin diseases, this treatise is the authoritative guide and handy reference. In its pages one finds the proper technic for the treatment of every important dermatologic disease in which radiation is of service.

NATHAN THOMAS BEERS

The Medical Clinics of North America January, 1945 (Chicago Number) Illustrated Philadelphia, W B Saunders Company, 1945 Published Bimonthly (six numbers a year) Cloth, \$16 net, Paper, \$12 net

This book is primarily a neurologic climic, with the exception of the last four chapters, but in its eighteen chapters by separate contributors it covers many of the up-to-the minute problems in this specialty. Moreover, the authors display excellent clinical material in clear form. The book is an interesting example of how much territory is covered in this medical clinic series. They make a fine reference system for the specialist, as well as the practitioner.

SAM PARKER

Narco-analysis A New Technique in Short-Cut Psychotherapy A Comparison with Other Methods and Notes on the Barbiturates By J Stephen Horsley Duodecimo of 134 pages, illustrated New York, Oxford University Press, first American edition 1946 Cloth, \$2 50

This small volume on Narco-Analysis is written by the man who first devised and named this psychotherapeutic technic. The greatest ment of this book lies in the fair and frank exposition by the author of what this technic can and cannot do. No exaggerated claims are made for it nor does he regard it as an infallible substitute for any other psychotherapeutic procedure. Neither does he regard it theoretically as something apart from the perceptions and principles underlying all psychotherapy. The author's nich clinical experience in the use of Narco-Analysis for psychologic research as well as for therapy, gives the reader ample opportunity to familiarize himself with its use. The book is well written and should be read by those interested in the subject.

SIMON ROTHENBERG

A Primer for Diabetic Patients By Russell M Wilder, M D Eighth edition Sevtodecimo of 192 pages, illustrated Philadelphia, W B Saunders Company, 1946 Cloth, \$1.75

This little volume is packed with important information for both physicians and diabetic patients. The style is unurually readable. The tricks of diet and dietary equivalents comprise the main problems facing most diabetics in their attempt to live socially acceptable lives. The dietetic sections of the book will prove an invaluable adjunct to both physician and patient in the achievement of their mutual goal—the patient's well-being.

It is debatable whether the sections addressed to the physician should be included in such a Primer, but since they are, it should be pointed out that the recommendations for fluid treatment of dehydration and shock are too conservative, and that blood should be used earlier and much more freely than advocated over half the patients with diabetic come die of shock without other cause of death

The Primer is recommended very highly for

practical life-regulation by diabetics

MAURICE TULIN

The Chest A Handbook of Roentgen Diagnosis By Leo G Rigler, M D Octavo of 352 pages, illustrated Chicago, Year Book Publishers, 1946 Cloth, \$6 50

This represents one of a series of handbooks dealing with the roentgen diagnosis of the various systems of the body. It is presented as an atlas and, as such, it is quite complete as it relates to the pathology of the pulmonary system and pleurn. The volume will, undoubtedly, find its appeal among those, other than roentgenologists, who are interested in the diagnosis of pulmonary conditions, it is unfortunate that the author, while describing the methods of examination, did not see fit to stress the dangers of fluoroscopy and radiography

RICHARD A RENDICH

The Human Ear in Anatomical Transparencies Descriptive text by Stephen L Polyak, MD, anatomic transparencies and illustrations by Gladys McHugh, and anatomic preparations by Delbert K. Judd, MD Quarto of 136 pages, illustrated Elmsford, NY, Sonotone Corp, 1946 Cloth, \$10.50

The format of this book is that of an atlas. The drawings are from actual specimens and are reproduced on transparencies which are so arranged that they are superimposed one upon the other representing serial sections. The text is well prepared and includes the embryology as well as the anatomy and physiology of the auditory mechanism. Included in the volume, too, is a discussion of the anatomy and physiology of the vocal mechanism.

SAMUEL ZWERLING

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Doctors, Drugs and Steel By Edward Podolsky, MDOctavo of 384 pages, illustrated York, Bernard Ackerman, 1946 Cloth, \$3 75

Dr Podolsky endeavors to tell something of what modern medicine does to banish disease and to pro-It is an ambitious saga of medicine, obviously dedicated to the lay reader but with a considerable appeal to doctors themselves Most of the descriptions are factual with some emphasis on the spectacular, as is evidenced by some chapter heads, Architects in Bone, New Life on Borrowed Organs, and Menders of the Maimed This seems to cover the field of modern medicine, a record of the many triumphs of clinicians and investigators Many of the procedures described are concededly experimental but are included because of the possibility of future significance and application

JOSEPH RAPHAEL

Mongolism and Cretnism. A Study of the Clinical Manifestations and the General Pathology of Pituitary and Thyroid Deficiency By Clemens E Benda, M D Octavo of 310 pages, illustrated New York, Grune & Stratton, 1946 Cloth, \$6 50 By Clemens

This book is well written. Benda, a neuropsychiatrist, has a scientific approach toward the

solution of the etiology of mongolism

An excellent description of the plica marginilas, with pictures showing the eye signs, is an indication of his lucid, painstaking, scholarly work that Benda goes too far in calling these individuals pituitary cretins, although the future may show that he is correct. The determination of prolans and estrogens is not given. We wonder why only one case of "cure" is reported following the use of the "thyrotropic hormone"

This book is enthusiastically recommended to anyone who is interested in endocrinology or mon-

golism, because of its excellence

BERNARD SELIGMAN

Psychotherapy in General Medicine Report of an Experimental Postgraduate Course Bv Geddes

Smith Octavo of 38 pages New York, Commonwealth Fund, 1946 Paper, 25c.

This pamphlet reports the experiences with a practical course in psychotherapy for general practitioners The difficulties as well as the benefits derived are discussed in detail Since the reactions of the student physicians are given, it would be profitable for individuals who are giving or contemplate taking such a course to study this booklet

ARTHUR J LAPOVSKY

Sex Problems of the Returned Veteran By Howard Kitching, M D Duodecimo of 124 pages New York, Emerson Books, 1946 Cloth, \$1 50

Dr Kitching's remarks are clearly written and cover in idealistic fashion and without evident condescension the problems of normal individuals facing the prospect of reunion and the months of readjustment afterward He describes sexual readjustment in an isolated sense, not relating it to the other problems of adjustments, economic and occupational, which are simultaneously encountered

The book is written for the laity and as such may have educational value It is not likely to give new insight to psychiatrists who are dealing with the

problems of the more seriously conflicted

EDWARD F FALSEY

Practical Malariology Prepared Under the Auspices of the Division of Medical Sciences of the Mational Research Council. By Paul F Russell, M D, Luther S West, Ph D, and Regunald D Man-well, Sc D Octavo of 684 pages, illustrated Philadelphia, W B Saunders Company, 1946 Cloth, \$8 00

The problem of malaria is one that concerns every section of the country today for there is hardly a village that has not had its citizens exposed to the danger while serving in the armed This volume offers a rather complete and descriptive treatise on malaria of interest to the general practitioner, the student, and the specialist

It emphasizes especially the importance of prophylaus and control—(1) by the administration of drugs, (2) larvicides, (3) drainage and filling, (4) control of adult mosquitoes, (5) control of man

The authors are especially qualified by their training and experience to make available in this monograph all reliable information gained to date in the fight against malaria

HENRY M FEINBLATT

Allergy in Practice By Samuel M Feinberg, M D, with the collaboration of Oren C Durham, and Carl A Dragstedt, M D Second edition Octavo of 838 pages, illustrated Chicago, Year Book Publishers, 1946 Cloth, \$10 50

This is the second edition of an excellent work covering the entire field of allergy Asthma and hay fever are exhaustively presented The chapters on pollens, pollen allergy, allergy to fungi, and treatment have been brought up to date view of the status of histamine and histamine antagonists in allergy provides a clear discussion of this timely subject

This volume can be heartily recommended to both the allergist and the general practitioner

MAX HARTEN

The Management of Obesity A Handbook for the General Practitioner By Louis Pelner, M D Octavo of 144 pages, illustrated New York, Personal Diet Service, 1946 Cloth, \$3 00

The author has prepared a satisfactory review of the subject for general practitioners. The principles are sensible and practical There are several case illustrations and a variety of food charts, diet lists, and low caloric menus

The presentation is almost entirely clinical with minimal reference to the chemical and physiologic disturbances in obesity Exception may be taken to the use of mercurial diuretics to remove fluid retained during menstrual periods of some obese women

The book is recommended

DUNCAN W CLARK

Principles of Hematology By Russell L Haden. Octavo of 366 pages, illus-MDThird edition Philadelphia, Lea, & Febiger, 1946 trated \$5 OO

This work is good because the style is clear, the diagrams are simple, and the case histories are in-With the newer knowledge gleaned from sternal puncture and splenic puncture, too much stress is laid upon the calculation of indices The latter are becoming less and less important since the advent of specific information obtained from bone marrow and splenic aspiration biopsies Still, for a concise knowledge of practical hematology, no one can afford to be without this book

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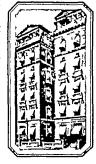
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## WHAT DOES THE MEDICAL SOCIETY OF THE STATE OF NEW YORK DO FOR ITS MEMBERS?

#### Workmen's Compensation Bureau

The benefits accruing to a member of the State and County Medical Society because of the existence and activities of the Workmen's Compensation Bureau are as follows

The State Medical Society, through its representation on Governor Lehman's Commission to revise the Workmen's Compensation Law in 1933, was originally responsible for the free-choice principle written into the Workmen's Compensation Law in 1935 by which an injured worker is entitled to select the physician of his choice for treatment

For the first time since the State Medical Society, years ago, relinquished the right to license physicians to practice medicine, the county medical societies were clothed with definite responsibilities of a professional and procedural nature. These included the qualifying and recommending of physicians for authorization to practice under the Workmen's Compensation Law, either as general practitioners, or specialists. The medical societies were clothed with authority to participate in the arbitration of disputed medical bills. Before 1935, all medical bills were fixed by the Industrial Commissioner through a medical bill calendar while, thereafter, the fees were paid in accordance with a fee schedule recommended by the president of the State Medical Society

Disputed bills were arbitrated by physicians Violations of the provisions of the Workmen's Compensation Law were placed under the jurisdiction in the first instance of the Workmen's Compensation Committees set up in each county of the State by the county medical societies. The disciplining of the physician was placed in the hands of the medical societies in the first instance, with provisions for appeal to the Industrial Council which also numbered among its members physicians recommended by the Medical Societies. The local county society compensation committees were authorized to recommend the establishment of physicians and employers medical bureaus, provisions for which were made in the law could be licensed without the inspection and approval of physicians familiar with local conditions. They, too, recommended impartial medical experts to decide difficult medical problems before the Compensation

referees

In addition to these functions, the creation of a State Medical Society compensation bureau, with a full-time director, afforded a means of integrating the work of the local county society compensation committees, which made for uniformity of practice throughout the State in relation to the administration of the Workmen's Compensation Law as it devolved upon the organized profession The entire machinery of qualifying physicians and changing their ratings from time to time in accordance with the changes in their qualifica-tions and practice was set up by the State Medical Society through its bureau and followed by the 61 county medical societies The Workmen's Compensation Bureau serves as a means of approach by physicians and county societies to the Department of Labor, to the more than 70 insurance carriers and numerous selfinsured employers and municipalities throughout the State in all matters pertaining to workmen's compensation procedures

The Bureau has been at the service of the profession for the collection of medical bills, and for the protection of the physician's rights in all compensation matters involving, not only the law, but the rules and regulations set up for its administration. Not only has the Bureau collected hundreds of thousands of dollars of disputed and unpaid medical bills, but it has interceded with the Department of Labor in facilitating the determination of liability so that medical bills in dispute and waiting payment could be paid. The Workmen's Compensation Bureau has independently, and in connection with the county medical societies, kept physicians informed of all pending workmen's compensation legislation, acquainted them with the provisions of amendments to the law, and represented them when necessary before the Department of Labor,

the Industrial Council, and other bodies

Numerous talks, lectures, round-table discussions, and other programs before county medical societies on the professional and administrative aspects of the Workmen's Compensation Law have been carried out in the course of the last ten years The Bureau has set up examining committees in roentgenology, and supervised the creation of other examining committees to determine the qualification of physicians where

the usual methods of reviewing qualifications were not adequate

There has been created a Joint Council, the members of which represent the various stock and mutual insurance carriers, the State Medical Society, and the State Osteopathic Society, for the discussion and clarification of workmen's compensation administrative matters, fees, and other procedures incidental to the treatment of patients and the carrying out of the law and rules and regulations governing same. There has also been created local committees in the large counties with joint representation to iron out disputes and foster good will, and to oil the machinery of workmen's compensation administration in the interest of good medical care to injured workers

The Bureau is in receipt of hundreds of letters of appreciation from physicians throughout the State testifying to the value of the services rendered them by this Bureau and, it goes without saying, similar service was rendered by many of the local county society compensation committees

The Workmen's Compensation fee schedule has brought into the pockets of physicians of this State, annually, from fifteen to thirty million dollars since 1935, the latter figure being more nearly correct for the period of great industrial activity incidental to the war

The above is just a sketch of the benefits that have accrued to a member of the State Medical Society The above services were rendered by the State Medical Society Compensation Bureau without additional

cost to the individual physician, and at considerable expense to the State Society

In certain of the larger county medical societies, a small annual or initial fee is charged for the maintenance of the local compensation committee but in no instance has this fee been fully adequate to support the work In most instances, the payment of this fee has been voluntary and not obligatory. No extra fee was ever charged by the State Medical Society for the service of its Workmen's Compensation Bureau in any or all workmen's compensation matters

DAVID J KALISKI, M D, Director

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## Officers—County Medical Societies—1947

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Albany	H L Nelms		A Vander Veer	Albany	F E Vosburgh	Albany
Allegany	I Felsen		E B Perry	Belfast	D Grev	Belfast
Bronx	S Cohn		G B Gilmore	Bronx	S Epstein	Bronx
Broome	J C Zillhardt	Binghamton	M A. Carvalho	Binghamton	J W Kane	Binghamton
Cattaraugus	R. F Garvey	Olean	W R. Ames	Olean	W R Ames	Olean
Cayuga	R. J. Thomas	, Auburn	D S Eisenberg	_Auburn	L H Rothschild	Auburn
Chautauqua	F P Goodwin	Jamestown		Dunkirk	C E Hallenbeck	: Dunkirk
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#### TOMPKINS SUPERVISORS APPOINT COUNTY BOARD OF HEALTH

Proceeding with the organization of the new county health district, the Tompkins County Board of Supervisors recently appointed a County Board of Health as required by Section 20-b, Article III, of the Public Health Law The members are Mr Paul S Livermore, representing the City of Ithaca, Mr Harvey Stevenson, Enfield, representing the County Board of Supervisors, and Dr Norman S Moore, Mr James E Rice, Jr, Mr Harry N Gordon, Dr Willard R Short, Dr Henry B Sutton, and Miss Eugenia Van Cleef, members-at-large The county supervisors have also taken steps to fill the position of County Commissioner of Health and to procure other essential personnel

This action follows formal approval by the State Commissioner of Health of a resolution passed vy the Tompkins County officials proposing the establishment of a county health district By resolution passed by the Mayor and the Common Council, the City of Ithaca will become an integral part of the

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In organizing its public health services on a county health district basis, Tompkins County may receive state aid and under the terms of a law which became effective January 1 of the current year and which provides that the State may reimburse a county annually for 75 per cent of the first \$100,000 ex-pended for public health work and for 50 per cent of expenditures in excess of \$100,000 Rensselaer, Schoharie, and Ulster have already taken advantage of the new law

Counties which adopted the county health district form of organization prior to the revision of the state aid law are Cattaraugus, Cortland, Columbia, West-chester, Nassau, and Suffolk Effective January 1, 1947, these counties will also receive state aid under the revised law on the same basis as newly organized county health departments -Health News, May 19,

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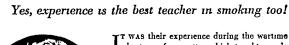
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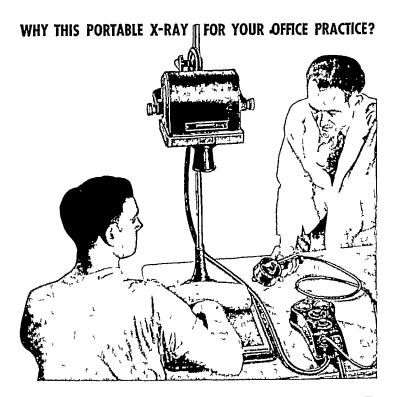
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Mad., 25:413 (Sept.) 1946.

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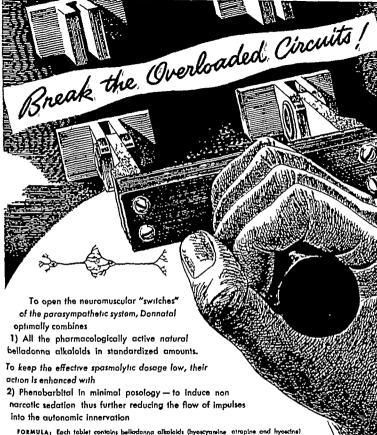
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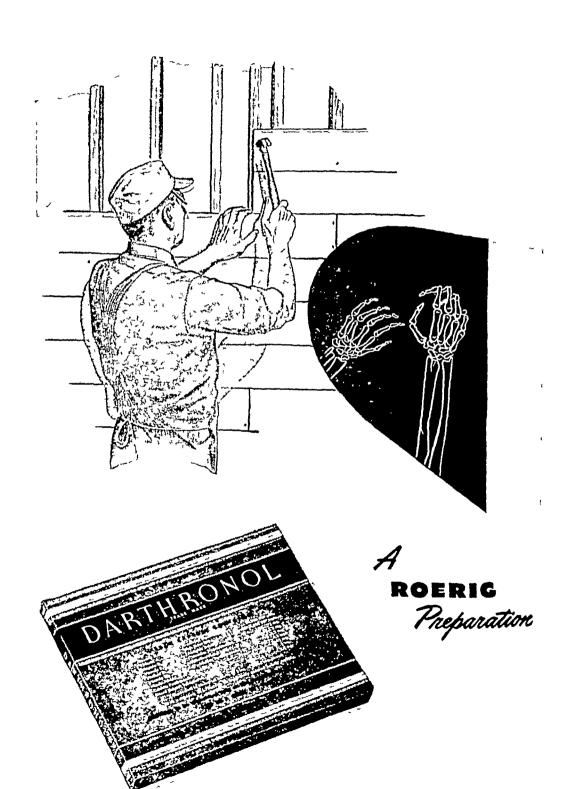


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(Equivalent to 3 mg of synthetic Alpha Tecopherol)

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ACTIVE DIURETIC . MYOCARDIAL STIMULANT BRONCHIAL RELAXANT

In Bronchial Asthma, Paroxysmal Dyspnea,



Cheyne-Stokes Respiration. TABLETS · AMPULS · POWDER · SUPPOSITORIES

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The active ingredient in TARBONIS is an especially processed Liquor Carbonis Detergens (5%), incorporated, together with landin and menthol in a special vanishing type cream

The high therapeutic efficacy of Tarbonis has been demonstrated by a decade of clinical use. Tarbonis is packaged in  $2\frac{1}{4}$  oz., 8 oz , 1 lb , and 6 lb jars

Physicians are invited to send for sumples of Tarbonis and Sul Tarbonis

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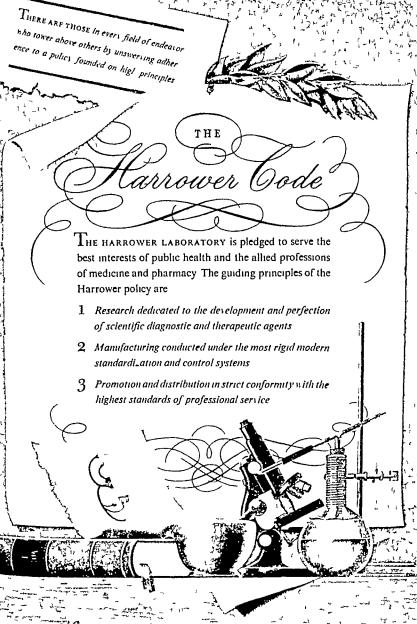
NEW YORK

# AVAILABLE

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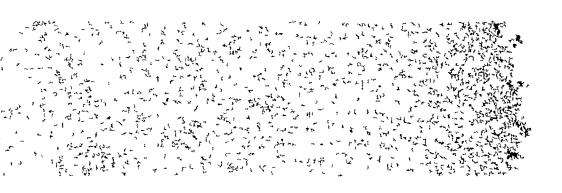


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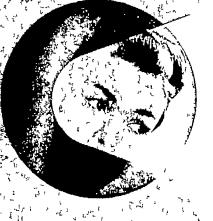
Pendarvon proves that Amino Acids don't need to be 'hard to take Served hot, Pendarvon tastes like bouillon—appetizing, heartening, rewarding—a welcome addition to the diet



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<sup>6</sup>Shoder S. LeAmer J. Obstel, & Ove. \$2/1 1944.

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Doctor..

Rare is the person who does not enjoy a piece or two of candy at the end of a meal. The satisfying goodness of candy creates an aura of well being which, postprandially, is conducive to good digestion of the meal just eaten

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These unique advantages of candies more than justify their inclusion in the daily dietary, not only of adults, but of children as well

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### for easier administration

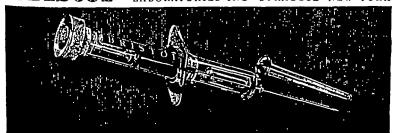
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This is a significant development in penicillin therapy Specify Bristol and obtain the benefits of LIQUID Romansky Formula

Supplied in one cc car tridges of 300,000 units with or without special syrings equipment and in 10 cc rubber-stoppered vials Needs no refrigera tion in storage or warm ing before use



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# saturation therapy

Following surgery, illness or injury with their tissue-depleting effects, the patient will usually require prompt replacement of nutritive factors. For this use, Solu-B with Ascorbic Acid provides all the major water-soluble vitamins of the B complex as a sterile dry powder, and ascorbic acid in an accompanying sterile solution for use as diluent. To administer, the ascorbic acid solution is drawn into a syringe and added to the vial of dry Solu B\* which readily dissolves and is promptly available for rapid tissue saturation after intramuscular or

#### RECOMMENDED DOSAGE

intravenous injection

Intramuscular One or two 5 cc. vials Solu B dissolved, respectively, in 5 or 10 cc. ascorbic acid solution, administered in two separate injections of 5 cc. each in different areas at the same time, or at six hour intervals.

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Each vial of Solu-B contains, as a sterile dry powder

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RIBOFLAVIN	10 mg
PYRIDOXINE HYDROCHLORIDE	5 mg
CALCIUM PANTOTHENATE	50 mg
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In packages of five 10 cc. size vials Solu B and five 5 cc. ampoules Ascorbic Acid 500 mg Sterile Solution. SOLU-B WITH ASCORBIC ACID



## SODIUM SALT for rickettsial infections





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Paba shortens the course and moderates the symptoms of

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Paba seems to be as specifically effective against rickettsias as sulfonamides or penicillin against susceptible bacteria

Prophylactic dose: 0.5 1 Gm daily

Therapeutic dose: 4 6 Gm. initially, followed by

2 3 Gm every two hours.

- 1 JAMA 129-1160 1945.
- 2. Delaware State M.J. 18:104, 1946.
- 3. JAMA 131,1364 1946.
- 4. JAMA, 132,911 1946.
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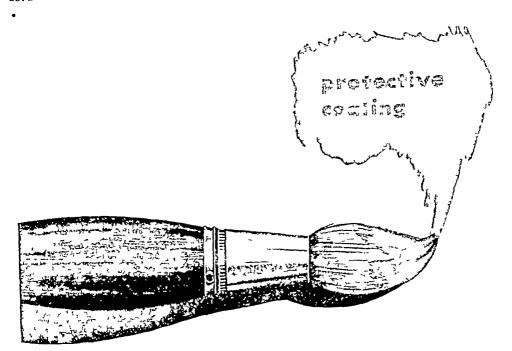
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# NEW YORK STATE JOURNAL OF MEDICINE

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**VOLUME 47** 

JULY 15 1947

NUMBER 14

## Editorials

#### Rocky Mountain Spotted Fever

Rickettsul disease has been noted in many places in this country. The popular designation of this frequently fatal illness is no longer appropriate and the almost epidemic occurrence in the eastern end of Long Island has aroused the attention of physicians, health authorities, and the public, as might be expected with a malady which is accompanied by a death rate of approximately 20 per cent. Perhaps Eastern spotted fever would be the better term. The tick is widely distributed in the areas where it has caused widespread infection among a number of hosts, among which the dog appears to be the favorite. The season for its depreda-

tions is largely during July and August, and in order to bring the matter to the attention of physioians, the Journal is devoting the majority of its pages in this issue to a timely symposium held at the Southampton Hospital last August under the direction of Dr Shepard Kreeh and authorized by the Board of Directors of that institution

The symposium is a well-rounded presentation deserving of the attention of practicing physicians who should make themselves acquainted with a disease which apparently may escape detection from lack of knowledge of its signs and symptoms.

#### Decay of the Family?

It is alleged that the institution of the family in Western civilization is going on the rocks. Life magazine discusses the question editorially, pointing out that according to Dr Carl Zimmerman, Harvard sociologist, "the Western family has collapsed twice before, in Greece about 300 B C and in Rome about 300 A.D., in each case mark-

ing the decline of those states." Decay of the family in Greece and Rome was marked by corruption, vanishing birthrate, demigration of parents, juvenile and adult delinquency, says Life

Certainly, accumulating statistical evidence seems to lend weight to the warnings from many sources that something is happening to the modern family Such a state

1 March 24 1947 p. 36

of affairs should be of the gravest concern to doctors of medicine It is probably inevitable that as civilizations evolve from their simpler, more rudimentary forms to then complex maturity the diseases of industrial middle age and early atomic-age senescence invade their cells destructively Spengler elaborated the thesis in his Decline of the West some time ago

If the family decays, what then becomes of the family doctor? The ready answer would be that he becomes the decayed-family doctor How near to that status is he now? If the decay of the family is marked by the symptoms recited in our first paragraph, should not medical educators, medical societies, and others interested in the future of medicine, give thought to the fact that a falling birthrate will necessitate fewer obstetricians and pediatricians, but probably more gynecologists, genitourinary practitioners, and psychiatrists The decayed-family practitioner could conceivably be a combination in one person of formerly separate specialties hest calculated to make of him a decayed-family friend and counselor His premedical curuculum could include law, sociology, the rudiments of police work, philosophy with special emphasis on Spencer and Spengler. abnormal psychology, the rudiments of statism, with possible some attention to English composition

The medical curriculum could well omit any attention to all but a certain few infectious diseases, substitute nuclear physics and diseases of irradiation, which may be reasonably expected to increase as more and more radio-active gases and other substances There you have the ideal, are released shortened course to produce the decayed-Medicine should be family practitioner ever on the elect to be functional in its service to humanity, wherever that may lead, even to the establishment of the qualifications and training of decayed-family doctors, if need be

#### The Pariah

Some time ago—it has taken us weeks to recover from it—ne received a shock attractive young lady—we use the term advisedly-consulted us Her symptoms were out of all proportion to her physical signs What they were is of no importance What caused their exaggeration is of great importance

She had been promised occupation in one of our oldest Long Island towns, one more than two hundred years old, and founded. unless we are much mistaken, by the Quakers, a sect which laid great stress on tolerance She could find no place to live We proffered the usual platitudes about the unusual housing shortage, the returning veterans, etc, ad nauseam She seemed strangely inconsolable

"That's not it, Doctor I never expected to find a house, or even an apartment I wanted was a room in a decent house There are plenty of them all over town I am barred because of my profession "

We straightened in our chair profession? How many were there? Wife, mother, scrubwoman, stenographer, typist, secretary, business woman Our incredulous mind whirled, stumbled, and finally came to a stop on woman's oldest profession It was the only one that we could think of that would bar this attractive girl from board and lodging in a respectable Long Island Any doctor, regardless of his private life, should be able to recognize the earmarks of a prostitute, professional or amateur Our patient had none of them

A moment, laden with uncomfortable silence, passed Finally, gathering courage, we asked,

"What is your profession?" "I am a schoolteacher"

We took three long breaths and flushed "And what is the objection to with shame taking a schoolteacher as a boarder?"

"Because we make so little money cause our clothes are not the latest thing Because we can't use lipstick " She was on "Because as inmates of a the verge of tears decent home we cannot put up as presentable an appearance as a factory worker "

Our New England mind flashed back a hundred years to the times in the State of Maine of which our great-great aunt used to tell us when money was unknown and learning was esteemed. Days when having the schoolteacher board with you during the term was an honor eagerly striven for and proudly worn Days when every farm accessible to the school-three, five, ten miles were distances of reasonable access—harbored a boy who worked for his board in order that he might get an educa-Days when pupils walked those distances, back and forth, drawn by the magnet of the schoolteacher Days when an education was a prize to be fought for. not a bolus to be rammed down the reluctant throats of unwilling children by the hands of an instructress socially regarded as slightly lower than the factory worker A pretty comment on a community that has traded the worship of Athene for the idolatry of Mammon

These reflections have been brought to the surface by the recent accounts of teachers strikes upstate We think all strikes are bad, and that if teachers strike, like policemen and firemen, it sets a peculiarly had example We recall the words of Calvin Coolidge—that unfashionable dead man who did not choose to run—"There is not right to strike against the public safety anywhere, any place, at any time"

Education should be the noblest profes sion in the world. The lowhest public schoolteacher has a moral opportunity which is vouchsafed to few, even were many of us sufficiently bold and unselfish to undertake it. When we speak of educators we are likely to think of college professors and college presidents. We forget at least most people do, how infinitely more important are the teachers who shape the lives of our children from their tenderest and most impressionable years up—or down

And these teachers cannot become boarders in a decent home in a decent community of old New England and Quaker ancestry

If that is not something for the medical profession to consider, it does not recognize what sickness is

#### Current Editorial Comment

Penicillin in the Treatment of Early Syphilis The multiplicity of the types and forms of syphilis, the numerous variations in the manner of administering penicillin, as regards the size and frequency of dosage, the preparation used, the route selected, the total dose, the period of time for one course of treatment, and the variations m the amounts of fractions F, G, K, and X in penicillin constitute a gigantic problem that is slowly being solved by the labors of thousands of clinicians contributing, from time to time, bits and fragments of additional information. In the January 4, 1947 issue of the Journal of the American Medical Association, the first fifteen pages of scientific matter were devoted to the elucidation of the problems of syphilis and the effects of treatment with penicillin. The three articles deal with early syphilis, neurosyphilis, and early congenital syphilis

Sternberg and Leifer<sup>1</sup> reported on their analysis of the records of 1,400 soldiers with early and latent syphilis treated between

June, 1944, and February 1, 1945 Each patient received a total dose of 2,400,000 units of sodium penicillin in aqueous or isotonic solution of sodium chloride, administered intramuscularly in 60 equal doses of 40 000 units every three hours over a period of seven and one-half days Reactions included the Herxheimer, urticaria, and various other cutaneous cruptions, but none was serious enough to require interruption of treatment.

The results of the single course of treatment in 1 400 soldiers were considered satisfactory in 90 6 per cent, and unsatisfactory in 94 per cent. The best results were achieved in those patients with seronegative primary syphilis—94 3 per cent, the next best in seropositive primary syphilis—89 9 per cent, and in secondary syphilis the results were favorable in only 83 per cent. Among 790 white patients, the unsatisfactory rate was 5 per cent among 610 colored patients, it was 15 per cent. Those rates probably are due to reinfections which are three times greater in the colored. This is to be ex-

pected, since the syphilis rate for negro troops has been consistently twelve to fifteen times that of white troops. In about one half of the patients, the cerebrospinal fluid was examined (all but 79 after six months) and found normal in 99 31 per cent. This report is encouraging, but its value is diminished because of the short period (over nine months) of follow-up. It indicates that in early syphilis, the need of more intensive treatment is in direct proportion to the progressive stages of seronegative primary, seropositive primary, and secondary

The results achieved in 100 cases (largely psychotic) of neurosyphilis treated with penicillin at the Boston Psychopathic Hospital, and followed for one year or more, are reported by Rose and Solomon 2 In all except 19 cases treated with penicillin alone, the patients received both penicillin and malaria, or penicillin plus treatment in a fever cabinet in amounts equal to about one half of the generally accepted standard course of treatment with penicillin consisted of a total dose of 3,000,000 units administered intramuscularly, the individual dose varying from 25,000 to 50,000 units, the time interval from two to four hours, and the duration of the course from five to fifteen days

Patients who failed to show improvement in clinical condition and in abnormal spinal fluid at the end of two months, and those with abnormal levels of cell count and protein content at the end of six months were retreated with penicillin alone in the same an ount and at the same frequency

The results in 75 patients with dementia paralytica were as follows with penicillin plus malaria, 71 per cent were improved, with penicillin plus fever cabinet, 63 per cent improved, and with penicillin alone, 66 per cent improved The average of all three methods of treatment was 69 per cent improved These results compare favorably with older methods of treatment 100 reported, retreatment was necessary in 36 patients Following treatment, the cell count returns toward normal in three to six months, the protein in six to nine months, and the Wassermann titer decreases more Of the 100 cases followed for a year or more, only 11 patients had negative Wassermann reactions Because more than a third of the patients required retreatment with penicillin, the total dose of that drug used in the treatment of neurosyphilis has been increased from 3,000,000 to 6,000,000 units

Five cooperating university clinics furnished the information assembled and reported by Platou et al 3 on the effects of penicillin treatment in 252 patients with early congenital syphilis Of the 252 infant patients, 86 9 per cent were colored, 53 1 per cent were girls, 857 per cent were less than one year old, and the remaining 143 per cent were in the second year of life total dosage of penicillin varied from 770 to 150,000 units per kilogram of body weight For schedules of 40,000 units or less (per Kg of body weight), the drug was usually administered in aqueous solution, divided into 60 equal doses given intramuscularly every three hours over a period of seven and one-For the larger schedules (100,000 half days units per Kg), the same plan was followed except that the total dosage was divided into 120 equal injections given over a period of fifteen days

In 171 infants the spinal fluid examined before treatment was abnormal in 62 6 per cent. Among 91 infants the spinal fluid was abnormal in 72 5 per cent. In the latter group, penicillin treatment reduced the abnormalities from 72 5 to 20 9 per cent. Abnormal spinal fluid is commonest in the younger infants, it improves under treatment, has a tendency to disappear or improve spontaneously, is rarely accompanied by clinically recognizable neurologic disorders, and has little prognostic significance. As time passed after treatment, the results were increasingly satisfactory. Clinical relapses in the entire group were only 2 4 per cent.

Among those followed for more than sixteen months, the patients clinically well and serologically negative increased from 11 1 to 69 2 per cent

Among 252 infants with congenital syphilis a single course of penicillin was followed by satisfactory results in 73 per cent, unsatisfactory in 91 per cent, and uncertain in 179 per cent. From their experience with this series of 252 cases, the authors recommend that syphilitic infants should receive a total dosage of at least 100,000 units of penicillin per kilogram of body weight, and that this amount should be divided into 120 equal intramuscular injections given at intervals of three hours over a period of twelve to fifteen days

<sup>&</sup>lt;sup>1</sup> Sternberg T H and Leifer W JAMA 133 1-5 (Jan. 4) 1947

<sup>&</sup>lt;sup>2</sup> Rose, A S, and Solomon, H C JA.M A 133 5-10 (Jan 4) 1947 <sup>3</sup> Platou R V, et al JAM.A 133 10-16 (Jan 4) 1947

## Scientific Articles

#### **SYMPOSIUM**

ON

#### EASTERN ROCKY MOUNTAIN SPOTTED FEVER

PRESENTED AT SOUTHAMPTON HOSPITAL, NEW YORK AUGUST 24, 1946

#### INTRODUCTION

SHEPARD KRECH, M.D. President of the Board of Directors

R OCKY MOUNTAIN SPOTTED FEVER, or Eastern Spotted Fever has been in digenous to this locality for many years. Of all the cases that have been recognized and reported in New York State one third have been treated in this hospital

It was not until a few years ago that the in terest of the health authorities, medical profession, and the public became fully aroused At that time several cases occurred which apparently had a definite relationship to infected dogs. Dr Norman H. Topping and Dr Charles C Shepard were sent here by the United States Public Health Service to review the cases and make some serologic studies of dogs. During the summer of 1946, Dr John K. Miller and Dr

Robert D Glasgow were delegated by the New York State Department of Health to set up a field laboratory and conduct entomologic studies at Montauk. It therefore seemed that the time had come for a thorough discussion of the problem and the Board of Directors of the Hospital authorized this symposium. It should constitute a scientific contribution of value as well as be of some educational significance. It is also designed as a demonstration of cooperative effort on the part of a small rural hospital and its staff with various government health authorities toward the solution of a community problem

Preliminary to a discussion of the various aspects of the problem 2 typical cases are presented

#### CASE REPORTS

Reported by Dr Herman B Rubler, Hampton Clinic, Hampton Bays Long Island—G L. a white man, aged 42 a native of Southampton, New York, was taken ill on July 1 1946 complaining of head aches of moderate severity, chills and fever with generalized aches and pains. Up to the date of onset he was working and felt perfectly well. During the day his headache became more severe and his temperature rose to about 102 F. The following day because of the severity of his headache and a continued rise in temperature to 104 F. the patient went to bed. He consumed a considerable amount of fluids and aspirin but took no nourishment After spending another sleepless night he sought medical advice. Hospitalization was recommended and on the following day July 5 he was admitted to Southampton Hospital.

The admission history revealed that the patient was a plumber by trade and had worked outdoors most of the time. He was compelled to lie in deep grass where ticks were prevalent and stated that be frequently brushed ticks from his clothing He gave no history of drinking water or milk from any doubtful source. His home surroundings were clean. He had not traveled outside of Southampton during the preceding few months.

The past history was negative except for the usual childhood illnesses. He had received no immunisa

tion against typhoid or typhus fever

Examination revealed a fairly well-nounshed white man who appeared acutely ill. His face was flushed his akin dry and the respirations were somewhat rapid. There was no cough. The pupils were equal and reacted to light and in accommodation.

His ears were normal and the mucous membranes of the nose and throat were injected The neck was normal except for some spasm of the muscles. there was no rigidity and the cervical glands were not en-The lungs were normal to percussion and auscultation The heart sounds were of good quality, with no murmurs or arrhythmias The heart was not enlarged, the pulse rate was 92 The blood The abdomen was soft and pressure was 134/84 the liver and spleen were not enlarged There was a well-healed scar in the right lower quadrant, the result of an appendectomy There were no areas of tenderness or spasm The extremities were normal and the reflexes were physiologic The skin showed a few scattered, rose-colored macules on the anterior surface of both ankles and wrists, which disappeared readily on pressure The temperature on admission was 105 2 F, the pulse was 96, and respirations were The blood count revealed a hemoglobin of 80 per cent, red blood cells 4,320,000, and white blood cells 4,400 with polymorphonuclear leukocytes 73, lymphocytes 24, and monocytes 3 The urine showed albumin 1 plus, occasional hyaline, granular, and pus casts, and a few white blood cells Felix-Weil reaction was negative

A diagnosis of Rocky Mountain spotted fever was made and the patient was given 2 Gm of para-aminobenzoic acid every two hours, together with 10 grains of sodium bicarbonate. An ice cap was applied to his head, he was given codeine and aspirin for headache, and pentobarbital for insomnia

The day following admission the macular rash on the ankles and wrists disappeared, and the patient felt somewhat better but toward evening his headache became more severe and the temperature, which had dropped to 99 8 F the previous evening, rose to 104 F. The rash reappeared on the wrists and ankles and also on the abdomen and chest. The Felix-Weil test was repeated and it was positive in the following dilutions. Proteus X K 1 40, Proteus X 2 1 80, Proteus X 19 1 80. On July 9 the Felix-Weil reaction was positive in the following dilutions. Proteus X K 1 40, Proteus X 21 320, Proteus X 19 1 160.

The para-aminobenzoic acid was continued, and the patient was given a transfusion of 500 cc of citrated blood on the sixth day after admission temperature remained elevated until the sixth day, when it went down to 99 F It became normal on the eighth day and remained so until his discharge on the thirteenth day His headache persisted until the eleventh day in the hospital He remained lethargic for seven days after admission, when he suddenly began to take notice of his surroundings He complained of partial deafness for this same period His rash persisted almost until his discharge from the hospital During the period of hospitalization he lost about 13 pounds At the time of discharge he felt weak and irritable and remained so for two or three weeks He also complained of insomnia was placed on a high calone diet, supplemented by vitamins and liver extract

The patient made an uneventful recovery and returned to work four weeks after discharge from the hospital, having fully regained his weight and strength

Reported by Dr Emma L Bellows, Southampton, Long Island—J P, a robust man, aged 45, was admitted to the Southampton Hospital July 20, 1946, with a diagnosis of tick fever

Six days prior to admission the patient was taken ill with chills, fever, intense headache and backache. The temperature ranged and great restlessness from 101 F in the morning to 103 F in the evening. Physical examination at his home was essentially normal He received 100,000 units of penicillin on two successive days On the morning of the fifth day of illness, he developed a slight, scattered rash on the dorsa of the feet The lesions were macular and rose-colored, and disappeared on pres-There were not more than ten or twelve mac-There was no evidence and no ules on each foot history of a tick bite, but the patient had a dog. had often picked off ticks without proper precautions and had suffered many flea bites

Upon admission, the patient was in no apparent distress except for headache. The rectal temperature was 102 F, the pulse was 120, and blood pressure was 120/80 The face was flushed, the gums red and slightly swollen, and the throat normal The pupils reacted to light and accommodation The sclerae were injected There was no discharge from the nose or ears, and the tongue was clean There was no rigidity of the neck and no palpable cervical glands The chest showed good expansion, was resonant throughout, and no rales were heard The heart was not enlarged, the sounds were regular and of good quality, and there were no thrills or murmurs The abdomen was soft, with no tender areas, and there was no enlargement of the spicen or The hands and arms were normal, on the dorsa of both feet were rose-colored macules which disappeared on pressure Later these became purplish in color and did not disappear on pressure They did not spread to his legs The knee-jerks were active

The patient was given an initial dose of 3 Gm. of para-aminobenzoic acid in chilled 5 per cent bicarbonate of soda, followed by 2 Gm every two hours. This was continued throughout his ten days' stay in the hospital. Other treatment was symptomatic.

On the second day his temperature dropped to 101 F in the morning and 100 2 F in the evening. It continued this way for three days, and then dropped to 99 4 F in the morning and 99 8 F in the evening for another three days, with occasional rises to 100 F. On the minth day the temperature was 98 4 F in the morning, and 99 2 F in the evening, and it was normal thereafter. The patient compluined of headache as long as he was receiving para-aminobenzoic acid, but this stopped when the drug was discontinued.

Laboratory Findings—The complement fixation reaction was positive On July 20, 1946, a Felix-Weil test was made, and the Proteus K reaction in 1 40 dilution was negative, Proteus 2 was negative, and Proteus X 19 in a 1 80 dilution was positive. The urine showed a specific gravity of 1 020, albumin was 1 plus, and there was sugar content. The blood had a 95 per cent hemoglobin, 4,880,000 red blood cells, 7,850 white blood cells with 77 per cent.

polymorphonuclears 21 per cent lymphocytes and 2 per cent monocytes.

On July 25 1946 the blood contained 5 500 white blood cells 60 per cent polymorphonetilears 39 per cent lymphocytes and 2 per cent money tes. On July 26 the Proteus \ 10 was 3 plus in a dilution of 1 20 3 plus in a dilution of 1 40 1 plus in a dilution of 1 80 and 1 plus in a dilution of 1 160 On July 29 the para aminobenzous acid blood level had a total of 4 40 4 01 free and 0 45 conjugated. The red blood count was 5 050 000 white blood count was 5 100 with 54 per cent polymorphonuclears and 46 per cent lymphocytes.

#### Conclusion

It will be noted that J. P. had a mild attack. After the para-aninobenzole acid was started his temperature came down by lysis his rash did not spread to other parts of the body. The muscle pains

in the back disappeared he was in good spirits but complained bitterly of a headache and attributed it to the drug as the headache always became worse soon after the administration of medicine. His blood count remained good in spite of large doses of para aminobenzole acid. There was no tendency to anemia or leukopenia or albuminuma. We were disappointed that we could not get his para aminobenzone acid blood level up to 10 mg per 100 cc. of blood which is considered the best level.

His dog was submitted for examination and the complement fixation test was strongly positive for Eastern spotted fover

We believe that para aminobenzone and definitely shortened the course of the disease in this man. Recovery was not spectacular but in comparing him with other cases in this neighborhood in previous years we feel that the short duration and lack of toxemia were due to the administration of the para aminobenzoic acid.

#### CLINICAL EXPERIENCES IN EASTERN SPOTTED FEVER

LERAY BARRETT DAVIS, M.D. Westhampton Beach, New York

(From the Southampton Hospital)

SINCF 1913 when the first recognized case of Lastern spotted fever on Long Island was recorded by Dr David Edwards approximately 100 have been reported in Suffolk County Of these 30 cases were admitted to Southampton Hospital during the period from 1933 to 1946 Statistics show that all cases in New York State exclusive of New York City occurred in Suffolk County except for 3 cases in Nassau County and 1 infection in a laboratory worker in Rockland County It, therefore becomes evident that this hospital has cared for almost a third of all cases reported in New York State, outside of New York City 1

There were nine deaths in the 30 cases a mor tality rate of 30 per cent, indicating the severe nature of the disease in this area. Men accounted for 57 per cent of the cases and women for 43 per cent. In the West most of the victims are men, but here they seem about equally divided probably because of the role played by the household dog, the favorite host of our Eastern tick. Dermacentor variabilis. The youngest patient was 2½ years old, the oldest 78

Strangely enough a definite history or scar of a tick bite was recorded in only 12 or 40 per cent of the cases Parker states that often a tick bite cannot be found 2 and Baker reports that attached ticks are not usually present. 3 This seems to lend strength to the theory that the Rickettera may infect through unbroken skin

All patients were exposed to ticks and in some of the severe cases a history of deticking dogs with bare fingers was given. This tempts one to dwell on Parker's 'reactivation theory' that the virulence of the Rickottan may be increased sharply by a fresh blood feeding and emphasizes the danger of ticks on household pets

One of the best definitions of Rocky Mountain spotted fover is Cecil s. Rocky Mountain spotted fever is a specific infectious endanguits, transmitted by ticks characterized by chills fever and a macular cruption, becoming petechial which appears first on the wrists and ankles."4

A careful study of the records seems to indicate that there are some moderate differences between the Eastern spotted fever, which we see locally and the Western or Rocky Mountain spotted fever described in most of the literature Recognized authorities have contended that one type is not the same or an extension of the other but that each had a separate origin many years ago 2.3 It is reasonable to assume that dissimilar features would exist

#### Symptoms

Of the symptoms none is more constant or outstanding than the headache. It is usually frontal but may be occipital. The expression is almost typical—the eyes closed but with a fearful tenseness as if the next minute would bring pain beyond endurance. Severe chils often usher in the illness followed by a fever of 104 F to 105 F and profuse diaphoresis. There is great malaise with muscle and joint achiness. Distincts and in somnia are common. Vomiting and diarrhea are rare.

#### Signs

The temperature soon rises to a high level, often spiking at first, but maintaining a plateau effect during the second week and declining by lysis the third week. The highest temperature recorded was 108 3 F in a young adult before death. The almost invariable termination of fever at twenty-one days without specific treatment was striking in this series. The pulse rate is usually from 90 to 110 per minute and in the early stages is quite disproportionate to the fever Baker noted this as characteristic.<sup>3</sup>

The headache is persistent and seems to be the forerunner of many signs of upper central nervous system disturbance The word "lethargy" is repeated constantly in the charts, delinium is common, and one young adult died in a wild dehrium of screaming and convulsions Restlessness, insomnia, twitching, confusion, deafness, and irrational behavior are words frequently found in the records Personality changes are not infrequent and are sometimes alarming to Rigidity of the neck is recorded in a few cases, but reflexes in general are not reported as abnormal, the highest areas of the central nervous system apparently receiving most of the pathologic insult due to minute circulatory disturbances

The rash is a diagnostic anchor and was typical in all 30 cases It is described in these records as a scattered, pink, macular rash, each macule from 1 to 5 mm in diameter, disappearing on pressure, and gradually within a few days becoming petechial and a deep red to purple color The eruption appears first on the forearms and wrists, legs and ankles, and spreads to the back, thighs, buttocks, and chest, in that order In short, it spreads centripetally, a differential point from typhus, which spreads centrifugally, from the trunk outward 3 A sign which we in this hospital have considered most reliable is the presence of the rash on the palms and soles In no case did the lesions go on to hemorrhage or necrosis, as described in the Western type The largest macules measured about 5 mm in diameter

Flushed face and conjunctivitis were described consistently, photophobia frequently

Another difference noted in this series was the infrequence of splenomegaly. In only 6 cases, or 20 per cent, was the spleen definitely noted as enlarged. Rose did not find an enlarged spleen <sup>5</sup> Baker notes enlargement of the spleen and often the liver as a regular finding in the West <sup>3</sup> Lymphadenopathy was not noted.

A cough was present in many of the cases, but pneumonia was a complication in only 10 per cent Diaphoresis was profuse and persistent—Studies of the spinal fluid were neither diagnostic nor characteristic In the fluids of 7 cases taken, the cell count ranged from 0 to 35, and globulin from none to a trace

The blood cytologic studies were likewise indeterminate If we accept 5,000 to 10,000 leukocytes per cubic millimeter as a normal range, according to Kolmer and Boerner, 70 per cent of the cases showed a normal count and 27 per cent showed an increase Throughout the series, the differential count was within normal limits. This differs from reports on the Western type, in which the leukocyte count averages 12,000 to 15,000 per cubic millimeter, and 10 to 15 per cent mononuclear cells.

Except in the terminal phase of the fatal cases, all urine analyses were remarkably free from abnormal change, even in the very acutely ill

The Felix-Weil tests in this series were reported by the New York State Department of Health, and ranged from 1 to 40 to 1 to 2,500 All sera were tested for agglutination by Proteus X 19 No positive reaction was obtained before the eleventh day of illness, which makes this test lose significance in the early days of a questionable illness Rising titers, to which we now attach so much importance, were noted consistently where serial tests were performed. Agglutination test with OX2 was done in 1 case in 1942, as was complement fixation. At present we are giving much attention to the latter.

### Complications

Pneumonia was a complication in 3 patients, or 10 per cent, all of whom expired The pneumonia was bilateral and basal, and all cases occurred before the advent of chemotherapy

Hemorrhage was not seen, nor was necross of the skin

One patient was discharged with deafness, but there is no notation as to its permanence

#### Deaths

Thirty per cent of this series expired There were no reports of postmortem examinations A study of the charts indicates that death usually occurred from a prolonged febrile exhaustion of the whole organism, very much like a typhoid state. The usual signs of circulatory failure were not observed, renal function seemed to hold, and the gastrointestinal traft seemed little involved.

#### Treatment

Before 1943 the treatment in this hospital was supportive and expectant Fluids, sponge baths, mild sedatives for restlessness, and exhaustive nursing care were given

In 1943 anti-Rocky Mountain spotted fever serum obtained from rabbits was first used Of the 4 cases in which it was administered, 3 re-

covered and 1 died In 1944, of 4 cases in which it was used, 2 recovered and 2 died In 1945, of 4 cases in which it was used, 3 recovered and 1 died This gives, for three years a mortality rate of 331/2 per cent, which is no improvement over the total mortality rate On analysis one observation can be made, namely, all patients who recovered were given serum on or before the seventh day of illness while in those who died, in all cases except one the serum was given after the seventh day The one exception was a 78-year old woman who received 80 cc of serum without improvement. In some cases the change in the temperature curve after serum was impressive In this small number of cases, one is not warranted in drawing conclusions Difficulty in obtaining the serum and fear of reaction often prompted dosage less than the recommended 1 ce per kilogram of weight.

Topping reported a 3.8 per cent fatality rate in patients treated by serum within three days of onset, as against a rate of 18.8 per cent without serum and with serum after three days, indicating that serum must be given early?

The sulfonamide drugs were tried briefly with

out benefit

Penicillin was used in 2 cases, each receiving 160 000 units daily for nine and thirteen days respectively, with no apparent change in condition or temperature. In one of these it was used in conjunction with serum, without avail in saving the patient

Baker claimed good results with intravenous injections of neoarsphenamine in aqueous metaphen, but I could find no confirmation of this

The past year brings the advent of para-ammobensoic and in treatment, suggested because of its success in typhus. I have not included the 3 cases in which the drug was used this year, for our experience has been too limited and our early dosage somewhat low

Anigstein and Bader reported good results from its use in guinea pigs, and Rose, Duane and Fischel had excellent results in a case reported in 1945. This drug holds great promise, but only time and experience will determine its value, as well as that of the serum, in reducing the serious mortality rate of this disease

#### Prevention

All residents of the coastal area of Long Island will attest to the fact that each year the number of ticks is increasing. The increase in incidence of Eastern spotted fever has not kept pace, but, fundamentally the control of the disease must aim at elimination of dog ticks. Fortunately, during the past year New York State has initiated two separate programs for the study of ticks in this area, and the Suffolk County Mosquito

Commission was empowered by the State Legislature to extend its activities to tick control

In 1945 a civic broup in one of the Hampton villages\* began a creditable campaign to prevent spotted fever Basing its program on information from Carroll N Smith,\* an authority on dog ticks, a three-point plan was used (1) education of the public, (2) attention to dogs, and (3) cleaning and burning of overgrown areas in the village Of the three the educational feature was the most successful Concise informative pain phlets were distributed by mail Thie pamphlets described the characteristics of the dog tick, how to avoid attachment, how to care for dogs by deticking, and the use of derris powder baths together with a few basic truths about Eastern spotted fever

During the last two summer seasons hundreds of persons in the Hampton area have been vaccinated with the chick embryo vaccine. Its value has not yet been determined. No case in this series had had vaccine prior to illness.

#### Summary

1 Since 1913, 30 cases of Lastern spotted fever, or about one third of all cases in New York State, exclusive of New York City have been admitted to Southampton Hospital These 30 cases are subjected to analysis The mortality rate was 30 per cent The cases were about equally divided between the sexes, and the ago range was 2/1, years to 78 years

2 History or scars of tick-bites were found in only 40 per cent, indicating that infection may

take place through unbroken skin

3 Essential differences from the reports on the Western type of spotted fever are noted These are in particular (1) lack of cutaneous necrosis, (2) infrequency of splenomegaly (3) normal leukocyte and differential blood counts and (4) equal occurrence in both sexes

4 The rash appeared in from three to five days after onset was discretely macular becoming petechal beginning on the forearms and wrists legs and ankles and spreading to the trunk. The appearance on the palms and soles was considered important

5 Examination of the spinal fluid is not help-

ful in diagnosis

6 Positive Felix Well agglutination reactions were not obtained before the eleventh day of ill ness. Rising titers in series tests were consistently noted

7 An impressive feature of this disease is its profound effect upon the higher sections of the central nervous system. Severe headaches lethergy, restlessness, insommu irrational behav

<sup>\*</sup> Westhampton Beach.

ior, and personality changes were frequently noted

Fever soon reaches 104 to 105 F, and de-8 clines by lysis in about twenty-one days pulse is usually disproportion itely low

Complications are few, pneumonia occur-One patient, on disring in 10 per cent of cases

charge, had loss of hearing

Fundamentally, prevention of Eastern spotted fever must aim at destruction of ticks, a Local attempts are now in difficult problem Many persons are receiving tick vacprogress one injections

From 1943 through 1945, 12 patients were 11 treated with anti-Rocky Mountain spotted fever serum, from rabbits There was no decrease in mortality among patients given the serum late in the disease, but decided benefit, with one exception, was obtained in those receiving it seven days or less after onset Early administration is mandatory

The sulfonamides and penicillin had no 12 effect in the very few cases in which they were Para-aminobenzoic acid showed promise in 3 cases, not included in this series

#### Discussion

Dr David Edwards, East Hampton, New York There are a few points on which I do not agree with Dr Davis, but perhaps it would be better at this time for me to go over what I saw years ago imagine there have been many cases of Eastern spotted fever which have not been recognized. The first case about which there was any question I saw ın 1912 Mrs M, wife of the gamekeeper at Gardiner's Island, complained of fever, headache, malaise, pains in the muscles, and a rash, and was very ill I thought at the time that it might be due to a tick bite At the same time, the owner of the property, Mr L G, was in the Presbyterian Hospital in New York City I obtained his chart report later, and from it learned that he had had a rash, headache, and other symptoms, not as severe as those of Mrs M, but it seemed to be the same type of illness His case had been diagnosed at Presbyterian Hospital as "fever of unknown ori-

The following year Mr H M, the husband, was taken with a severe illness He had been bitten by a tack and evidence of the bite-a brown spot about the size of a 5-cent piece on the right foot-was present when I saw him He had a rash which appeared first on the extremities-palms, soles, wrists, and This eruption was macular at first and then became hemorrhagic, petechial It disappeared under pressure at first, but not later He was very ill for a long time, and still feels that his poor health after all the intervening years is due to the tick bite I haven't seen him lately At the time of his illness I got Dr Cunningham from the training ship, Newport, and Dr Lewis also to see the case with me, and

we came to the conclusion that we should report it in the United States Public Health Service Dr D L. Van Dine came to town and, as I recall it, felt we did not have the variety of tick at Gardiner's Island which would carry the disease I still thought that there was a possibility

As far as I know, we had no more cases until 1924 when a case occurred in East Hampton Consulta tion with Surgeon-General Kirk, Sergei Bersukoff from Russia, who had had extensive experience with typhus, and others brought forth different oninions.

A Weil-Felix test was positive

I have reported 18 cases since 1912, 3 before 1916 when the Weil-Felix test was first used for diagnosis Since that time there have been positive reactions in all cases except one in which the patient died before the blood could be collected. The first case I reported to the New York State Department of Health was in 1933, that of M D of Montauk The State Department did not require this disease to be reported until later

The cases I have seen have shown pronounced toxemia as in a severe case of influenza, with eyes injected, great restlessness, severe headache, hyper sensitivity to touch, chills or chilly sensations, and muscular soreness Most of my cases did have some rigidity of the neck, and this is where I differ from Dr Davis, and most of them at some time during the illness did have an enlargement of the spleen The rash was as he describes Although I questioned its beginning on any other part of the body than the extremities, in reviewing some of my old charts I found that one definitely had it on the body first In regard to necrosis, 1 case did have definite necrosis and blebs as big as a thumbnail, just before the patient died

The serum treatment has seemed very satisfactory when given early In 1 case in which we thought the patient was going to die, with a temperature of 107 F, the serum was given intravenously and the next morning the patient was better As far as this new drug, para-aminobenzoic acid, is concerned, I don't know anything about it In my total cases, one child and five adults died, making six deaths out of the 18 cases, so the mortality in my experience was fairly high

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#### THE EPIDEMIOLOGY OF ROCKY MOUNTAIN SPOTTED FEVER\*

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THE epidemiology of Rocky Mountain spotted fever is so intimately associated with the blology of the tick that transmits the disease that I think it is appropriate to review the life history of the tick

There are three proved vectors of Rocky Mountain spotted fever in the United States Derma centor andersoni, which has been known as a vector since Ricketts work in the early 1900 s Until 1930, it was thought that Rocky Mountain spotted fever occurred only in the West. In 1930 Dyer Badger, and Rumreich in Washington. DC actually isolated the virus from nationts and from the D variabilis, or the so-called brown dog tick of the East and proved that Rocky Mountain spotted fever was in this locality About two years ago Parker and some of his associates proved that the tick Amblyomma americanum is also a vector along the Gulf coast of the United States There are many potential vectors, for example Rhipicephalus sanguineus the so-called kennel tick is a perfectly good vector in the laboratory but it has never been proved that it is infected in nature

The two ticks in which we are particularly in terested D anderson; which is the common vector in the West and D variabilis in the East have a complicated life cycle. Male and female feed on one of the larger mammals such as the dog cattle, or deer and during feeding they copulate. The female is fertilized and the male dies The female drops off after ten days and lays from 3 000 to 6 000 eggs. These hatch into larvae after a few days They are very tiny and feed on small rodents, field nuce rabbits, etc. They then moult into nymphs and again feed on small rodents The nymphs or the adults ' overwinter, and the following season they feed again on mammals and so the cycle continues

The interesting part about the life cycle of the tick is the fact that if the female is infected she passes the virus on to her eggs it is then passed through to the larvae and the nymphs and back to the adult so that the virus of Rocky Mountain spotted fever can be propagated by transovarial transmission. Thus, the ticks can serve not only as vectors but as reservoirs. Actual proof of animal reservoirs in small mammals has never been established although many have tried. In our simple philosophy of biology it seems that a

\* No formal paper presented. This represents notes taken during extemporaneous t. ik.

reservoir is unnecessary when it is known that the tick is perfectly capable of transmitting the disease from generation to generation transovarially

In humans the endemology follows the biology of the tick The season of greatest provalence is that in which the ticks are most abundant in any given locality usually starting in April and continuing until some time after August or Septem ber depending on the humidity and temperature The usual peak of Rocky Mountain spotted fever as we see it in Washington, D.C., Maryland and Virginia is about the last week in June and the first week in July There is a gradual progression. until June or July and then a gradual falling off until about August 1 or 15 after which the disease becomes rather rare. A case which was acquired by tick bite was reported in Virginia in December but that was during an extremely mild fall with no early frosts.

Geographically Rocky Mountain spotted fever is now located throughout the United States All of the states with the exception of five three of the New England States, Michigan, and Wisconsin have reported cases contracted within their borders. Each year there seem to be an increasing number of cases reported but we all feel that this is not a true increase in number but rather an increase in recognition of the disease since doctors are becoming more familiar with it. Each year an additional county is put on our spot map. Even though the first reported case was in the 1030 s it probably existed in the locality for many years before that

The disease is acquired where ticks are contacted People on the streets of New York City do not contract Rocky Mountain spotted fever On Long Island they do get the disease because they contact ticks. A simple example of the epidemiology of Rocky Mountain spotted fever could be given if we had a sufficient number of cases in golfers. I am sure we could correlate the incidence of spotted fever with the quality of the golf The good golfer would not contract Rocky Mountain spotted fever but the poor golfer would because the better the golfer the more he sticks to the fairway and the poorer the golfer the more he is in the rough such as Washington where we see a considerable number of cases of Rocky Mountain spotted fever each year it has always been observed that the case usually occurs in the house at the end of the street, where bushes and underbrush are close by

It is also a disease we where the children play see in people engaging in recreation

The morbidity and mortality in Rocky Moun-In the whole United tain spotted fever vary States, there are only 500 or 600 cases each year Of these, the gross fatality rate, considering all ages, runs about 20 per cent However, in the West the mortality is higher than in the East The question comes up as to whether we have had actual importation of Rocky Mountain spotted One way it could be accomfever from the West plished would be by importing the tick, D ander-The eastern tick is D variabilis extensive studies have been made trying to find D andersom in the East, but it has never been Therefore, the chances of importation of Rocky Mountain spotted fever from the West seem rather remote If it were actually imported from the West, we should see more or less of a string of known cases along lines of com-We would expect to find cases of munication spotted fever along railroad tracks or highways A pediatrician in Wash-This has not occurred ington, after seeing cases of Rocky Mountain spotted fever in children, said "This disease has been here for many years, but we have always called it black measles"

I believe that perhaps Rocky Mountain spotted fever has been here for many years, probably masquerading under all sorts of diagnoses

The question of East and West in Rocky Mountain spotted fever is one of considerable interest It is always said that the disease in the West is severe and here in the East relatively mild also said that the strains isolated in the West are severe strains, while those from the East are mild A few years ago we had occasion to isolate some 19 or 20 strains of Rocky Mountain spotted fever in the East and found both mild and severe strains, some just as severe as those in the West Several years after that we did the same thing in the West and found the strains to be both mild and severe So, as far as the strains are concerned, we could find no difference between the East and West To carry that on a little further. we examined statistics for the states of Maryland and Virginia for ten years, as compared with Montana and Idaho When statistics for those states were broken down by age, we found practically no difference In children below the age of twelve, in both localities, the fatality rate was 12 per cent, between the ages of twelve and thirty-nine, it was 15 per cent In adults above the age of forty there was a mortality of 40 per cent

How, then, do we evplain the difference between the 28 per cent gross mortality in the West and 19 per cent in the East? We found that over 50 per cent of cases in the East occurred in children below the age of twelve, and most cases in the West occurred in adult men above the age of The difference in the age distribution is a very simple explanation of the apparent increase in the fatality rate in the West as compared with Rocky Mountain spotted fever is a recreational disease in the East, occurring chiefly in children playing in tick-infested areas. In adults it occurs chiefly among golfers and fishermen, and others seeking recreation In the West it is an occupational disease among shepherds, woodsmen, and hunters There, women and children do not have the same contact with the wood tick as they do with the dog tick in the East There is no difference clinically in Eastern and

Western Rocky Mountain spotted fever Walter Reed Hospital, cases from the East and West were practically identical clinically The question comes up of dogs, and at this

point I feel a little embarrassed talking about dogs and Rocky Mountain spotted fever, because it was in this community that the first such observations were made Dr Krech contacted us in 1943, along with certain members of the County and State health departments, and we came up to see one of Dr Krech's neighbors had a Doberman pinscher dog which had lived in New York City and had never come into contact with ticks before Several weeks after coming here, the dog became acutely ill, and a diagnosis of streptococcus throat was made The dog had a temperature of 105 F, was not eating well, and was coughing It was given sulfanilamide weeks later the owner became ill with a typical case of Rocky Mountain spotted fever, and in studying the serologic reactions we found that the dog's complement fixation test was extremely high, and the owner of the dog also had a positive Following up this complement fixation reaction lead, we conducted several surveys on Long Island and found if we took dogs from families in which Rocky Mountain spotted fever had occurred, we obtained an unusually high titer from the dogs

In dogs selected from regions where there was no Rocky Mountain spotted fever, we found a low incidence of positive complement fixa tion reactions In Chicago and Los Angeles, where there is very little Rocky Mountain spotted Sera from fever, all the dog sera were negative the East where there is Rocky Mountain spotted fever were both positive and negative, but the highest incidence of positive reactions was from the dogs selected from families which had a case of Rocky Mountain spotted fever lead us to suspect that the dog has a more inti mate part in the epidemiology of Rocky Mountain spotted fever than previously has been con sidered

We know that the feces of the tick are highly infective We know also that the celome cavity containing freshly ingested blood is highly infectious We know that the organism of Rocky Mountain spotted fover can certainly penetrate the unbroken skin of an animal, and also infect through inhalation, as in other rickottsual disease We, therefore, could postulate that the feces of the tick that is feeding on a dog may get on the fingers of the owner through potting or, through potting the dog be dispersed into the air and be inhaled, or get into the conjunctival sac. Therefore, it is not at all impossible that the dog may be a great source of danger to its owner.

This summer we had occasion in Washington to see a patient with a suspected case of Rocky Mountain spotted fever who had been suck only two or three days, too early for positive scrologic reactions or for the appearance of the msh But the family dog was bled, and the titer of its serum was found to be extremely high Therefore, we treated the patient for Rocky Mountain spotted

fover which it was actually proved to be several days later Perhaps it was a coincidence, but it is surely at least interesting enough to warrant considerably more work.

Dogs are susceptible to Rocky Mountain spotted fever Badger in 1934 inoculated dogs in the laboratory and could recover virus up to ten days after inoculation. He found that dogs hying in a locality where Rocky Mountain spotted fover was provident were not susceptible but young dogs who had not had contact with the disease were susceptible and developed fever lack of pep, listlessness and cough and one of the clinical features of Rocky Mountain spotted fever in humans is frequently a dry, nonproductive cough

Our experience in this community has been a very valuable one Whether the dog will prove to be as intimately connected with Rocky Mountain spotted fever, as we now suspect, remains to be seen and Long Island is an excellent place in which to continue studies of that sort

#### DIAGNOSTIC AIDS IN ROCKY MOUNTAIN SPOTTED FEVER

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THE preparation and use of diagnostic antigens have not been my special field of endeavor, but I shall try to give you a few ideas as to the value and use of certain laboratory aids in the diagnosis of Rocky Mountain spotted fever

When human beings become sick with a disease characterized by a rash and high fever and the cases develop in tick infested areas where only Rocky Mountain spotted fever is known to occur then it is relatively simple on epidemiologic grounds alone to exclude other ricketteral dis-Thus, in certain areas of the United States, such as Long Island and the Rocky Moun taur area of the West where endemic typhus does not occur or is an extreme rarity when a person develops an illness characterized by high fever and a rash it is naturally thought that the patient must have Rocky Mountain spotted fever those areas where both endemic typhus and Rocky Mountain spotted fever occur, such as along the eastern seaboard in Maryland Virginia, North and South Carolina, Georgia, Alabama, and Texas, the problem of dugnosis becomes more difficult. In addition, we have come to be aware of another nekettsial disease, "Q fever, which may also be transmitted by ticks and which has been shown to be the causative agent in two recent outbreaks of infection in stockyard and packing house workers in Amarillo Texas, and Chicago Illinois, respectively Thus, it is apparent that it has become necessary to develop reliable laboratory methods for the differential diagnosis of various rickettsail infections

#### Chnical Diagnosis

As the other speakers have mentioned, one of the distinguishing clinical features of Rooky Mountain spotted fever is the fact that the disease most often produces a rash that appears first on the extremities and then extends centripically to the trunk, whereas in the case of epi demic or murine typhus, the rash usually appears first on the trunk and then spreads centrifugally to the extremities. Thus far, no distinctive rash has been observed in Q fever

#### Laboratory Diagnosis

The Weil Felix test, based upon the production by certain of the pathogenic rickettsiae of non specific agglutinins against the 'O' nonmotile variant of certain Proteus strains, has been of value in helping to differentiate certain rickettsial infections from nonnecestical infections. The positive agglutination of OX strains of Proteus in most instances indicates that the disease is rickettsial in nature. The three type strains of

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Proteus in general use for the Weil-Felix test are the OX 19, OX 2, and OXK—It is not possible to differentiate between epidemic typhus, murine typhus, and Rocky Mountain spotted fever by using the Weil-Felix test, since all three of these diseases may produce agglutinins to OX 19 in high titer.

Rocky Mountain spotted fever cases may produce high titer agglutinins against OX 2, but this test cannot be relied upon as an absolute diagnosis. Scrub typhus cases as a rule show agglutinins against OXK, and such reactions are usually interpreted as of diagnostic significance. The sera from "Q" fever cases do not contain agglutinins for any of the known OX strains of Proteus.

In recent years, following the discovery that rickettsiae could be grown readily in the yolk sac tissue of a fertile hen's egg, or on agar tissue cultures, it has been possible to prepare washed rickettsial suspensions of sufficient purity to use in agglutination tests

The agglutination tests are truly specific and readily differentiate between the various types of rickettsial infections, but the preparation of purified rickettsial suspensions for such tests is both laborious and expensive, and most laboratories cannot afford to employ them

On the other hand, numerous investigators now have shown that specific differentiation may be obtained with the complement fixation test by using antigens prepared from rickettsiae grown in the yolk sac tissue of fertile hens' eggs on agar tissue cultures or in the lungs of infected animals. Complement fixing soluble antigens are more readily prepared than are purified suspensions of nickettsiae for agglutination tests and the results obtained are quite specific and reliable

The test employed is essentially the Kolmer and Boerner technic used for syphilitic tests, in which a greater sensitivity is secured by storing the mixtures of serum, antigen, and complement overnight in a refrigerator before adding the hemolytic serum. Recently it has been found in our laboratory that soluble antigens of greater purity and specificity can be prepared by extracting them with benzene and then concentrating them by sodium sulfate precipitation.

Such purified antigens possess the distinct advantage of not giving false positive reactions in the presence of syphilitic or malarial serums, whereas nonpurified antigens quite often yield false positive reactions

In conclusion, the complement fixation reaction is without doubt a more reliable method for determining past infection with spotted fever or other nickettsial infections than is the Weil-Felix test,

since complement-fixing antibodies may persist in significant amounts for ten years or more after illness, whereas the Weil-Felix test becomes negative in less than a year following infection. However, it should be pointed out that the complement fixation test as used at present is not entirely satisfactory for diagnostic purposes, since complement-fixing antibodies do not appear in significant titers until the eighth to tenth day after onset of illness, and thus much valuable time may be lost before a positive diagnosis can be made.

Studies are now in progress in a number of laboratories, aimed at correcting this serious handicap in our present diagnostic methods, and it is hoped that success will be achieved along these lines in the very near future.

#### Discussion

Dr Franklin M Hanger —Rickettsial parasitism is widely dispersed in nature, where it is especially prevalent among the arthropods. In some instances, such as the one under discussion, the agent of spotted fever is so efficiently adapted to the infested host that no disability is caused to the tick transmitting the disease. Man is but an incidental participant in the life cycle of this interesting group of micro-organisms.

Dr Cox has played an important part in developing laboratory methods for distinguishing various rickettsial infections, such as spotted fever, from certain forms of typhus It was he who devised methods for cultivating the various micro-organisms in the yolk sac and obtaining specific antigens in sufficient quantities for satisfactory complement fixation tests and other immune reactions calities where only one of the rickettsial infections prevails the diagnosis may be assumed with reasonable assurance, but in certain regions, such as in some of the southern states, or in New York City, various types of rickettsial disease coexist and can be differentiated positively only by serologic tests Many longstanding controversies, such as the rela tionship of Brill's disease to epidemic typhus, or the specificity of Western and Eastern spotted fever, at last can be settled satisfactorily by these meth ods

From a clinical standpoint, prompt diagnosis is important, since serum therapy and para-aminobenzoic acid are most effective when administered early in the disease Unfortunately, laboratory aids such as the Weil-Felix and specific immune reactions appear too late to be of great practical assistance. Physicians in regions where spotted fever is endemic constantly must bear in mind the possibility of this disease and examine carefully all febrile cases during the tick season for rash and other distinguishing features of the disorder. We must still depend upon clinical acumen for the recognition and effective management of this disease.

#### VACCINE PROPHYLAXIS OF ROCKY MOUNTAIN SPOTTED FEVER\*

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R OCK1 MOUNTAIN spotted fever vaccine is prepared by two mothods. The older method, developed by Spencer and Parker uses ticks infected by feeding on infected animals. The other method is based on the observation by Cox that abundant growth of the organism of Rocky Mountain spotted fever may be obtained in the yolk sars of fertile hear' eggs.

The processing of this vaccine is the same as that developed for typhus vaccine by Topping as a modification of a method suggested by Craigie

The reactions to these vaccines depend principally upon the impurities present in them namely, tick or yolk sae material. The more frequent reactions for each type of vaccine are sunilar to that observed after typhoid vaccination with local soreness and swelling and if severe some constitutional reaction. Occasionally on repeated doses of tick vaccine, increased reaction with considerable edema is observed.

Data on reactions to the yolk sac vaccine may be obtained from the administration of typhus vaccine to some millions of troops during the war-In these men, one death with anaphylactoid symptoms occurred in a man with definite history of sensitivity to eggs and chickens Several other severe reactions with similar symptoms were also seen and these again in men with histones of sensitivity to eggs and chickens. One death following the administration of Rocky Mountain spotted fever vaccine has also occurred this in a child under treatment for sensitivity to eggs, among other things. Thus it would seem that these severe anaphylactoid reactions could be prevented by taking a short history and when this discloses sensitivity either administering tick vaccine or avoiding vaccination altozetber

As for efficacy, it would seem that tick and yolk sac vaccine are equally potent. Its ability to prevent death was fairly well demonstrated in the laboratory where before vaccine, laboratory infections were nearly always fatal, and where since vaccine has been used cases have been mild and almost uniformly nonfatal

Data from the field are difficult to collect but

everyone seems agreed that cases tend to be prevented by the vaccine, and when they do occur they are much modified

The question about vaccine most frequently rused is to whom should it be given? First of all we may say that laboratory personnel working with the agent should be well vaccinated before they start. Others for whom vaccination should be considered are persons subjected to heavy tick exposure. This group includes those whose occupations cause them to go frequently into tick infested areas and it also includes those whose play and recreation entail exposure to ticks.

What is a heavy enough exposure to make vac condition necessary is not too easy to answer However at the two extremes are those who get only two or three ticks a season who would probably not need it and those who find ticks on themselves each day for whom it night be recommended

Another group for whom vaccino can be con sidered is the owners of dogs that range in tick areas. It would seem that the owners of those dogs which frequently pick up ticks should receive the protection of vaccine.

The best time to administer the vaccine is about a month before the expected exposure. Its dosage is perhaps best in three injections of 1 cc each a week apart, although two injections of 2 cc each have also been recommended

A question which frequently arises is whether a person already bitten by a tick should be vaccinated. Vaccine given at that time would probably not give much protection against that tick bits since the incubation period of the disease is so short.

However vaccine given then would afford protection for future tick attachments which frequently can be expected

When a person has been well vaccinated, the repeat dose the following year can probably be cut to one injection

It should be emphasized that vaccination does not render unnecessary the usually recommended directions for personal hygiene. These include avoidance of tick areas whenever possible a thor ough personal inspection for ticks after exposure, and constant watching for ticks while in tick infested areas.

<sup>\*</sup> No formal paper presented. This represents notes taken during extemporaneous talk

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# PATHOLOGIC CHANGES IN ROCKY MOUNTAIN SPOTTED FEVER

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(From the Southampton Hospital)

THE gross lesions in Rocky Mountain spotted L fever in most cases are neither striking nor characteristic A macular rash, appearing first on the wrists and ankles and later extending to the trunk and face, has been described hemorrhages are usually seen in the skin and serous membranes Scrotal swelling and, at times, gangrene of the tonsils may be encountered in the more chronic cases The viscera reveal the cloudy swelling which is seen in any disease accompanied by high fever A mild to moderate enlargement of the spleen may be present. The meninges may appear normal, or they may show mild edema and hyperemia

The histologic changes are fundamentally those of an acute, specific, infectious endangutis, with swelling and proliferation of the endothelial cells Necrosis and thrombosis then occur in the small The specific characteristic of the lesions is the presence of the inclusion bodies described by Ricketts 1 The rickettsial bodies can be demonstrated within the endothelial cells smaller vessels-capillaries, arterioles, and venules-are affected Swelling of the cells leads to narrowing of the lumina, and necrosis of the wall results in small hemorrhages of the petechial The thrombi are formed from necrotic endothelial cells, fibrin, and red cells stages of the rash are produced by stasis in the capillaries due to the narrowing and occlusion of the small vessels The later hemorrhagic character is due to necrosis with capillary hemorrhage Varying degrees of perivascular infiltration of lymphocytes and larger monocytes are seen around the vascular lesions

The above changes have been observed in practically all organs, but especially in the testicles, tonsils, skin, and brain They have been described in the myocardium, kidneys, spleen. liver, and in sympathetic ganglia

The nckettsial bodies have been demonstrated in the endothelial cells, stained with Giemsa's method, by Wolbach 2 They are pleomorphic in character, occurring chiefly as minute diplococcus-like bodies in the endothelial cells of the vascular endothelium, but, also, in smooth muscle fibers and detached endothelial cells bodies have been found by Conner in the blood and in cell-free plasma after prolonged centrifug-They have the appearance of pleomorphic They may be bacıllary, lanceolate, or bacteria

diplobacillary, and some have flat ends joined by nonstaining material The free ends are more pointed than those of pneumococci Solid-staining or one or two chromatoid bodies may be seen.

Lesions seen in the guinea pig are pronounced swelling and reddening of the scrotum and eyelids, ulcers of the paws also may be seen Rickettsia can usually be demonstrated in the scrotal tissue

Hassin<sup>8</sup> has described the lesions found in the human brain as a nonsuppurative meningo-encephalitis analogous to the type caused by typhus fever (Fig 1 on opposite page) The vascular lesions are similar to those seen in other organs (Fig 2) The cellular infiltration is monocytic The adjacent brain tissue reveals varying degrees of degeneration with accumulation of fat products resulting from degeneration The lesions are scattered throughout necrosis the brain

In the liver (Fig. 3), the lesions again reveal vascular damage, thrombosis, and cellular infiltration in the perivascular stroma of the portal Parenchymatous degeneration of the areas The lesions in the skin liver cells is present (Fig 4) are those of vascular damage and lymphocytic infiltration, and the myocardial lesions are of the same puttern

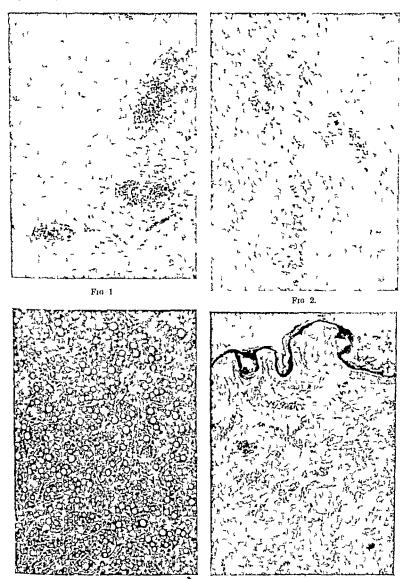
Fundamentally, the lesions are similar in na-Invasion of endothelial ture wherever found cells by the Rickettsia, endothelial swelling, narrowing of the lumen, stasis, thrombosis, necrosis, and hemorrhage, together with varying degrees of perivascular infiltration of lymphocytes and mononuclear cells are the fundamental changes seen Vascular occlusion results in ischemia which, in association with liberation of toxic products, leads to the production of the changes seen in the immediately surrounding tissue The seventy of the clinical picture depends upon the degree of involvement, or the number of such focal lesions present

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<sup>\*</sup> Pathologist Southampton Hospital.

I am indebted to Dr John K Miller associate director of the Division of Laboratories and Research of the New York State Department of Health for permission to study the material from 2 cases The findings in one of these were published by Maillard and Hazen' in the New York State Journal of Medicine.

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# INSECT VECTORS OF ROCKY MOUNTAIN SPOTTED FEVER ON LONG ISLAND

JOHN K MILLER, M D, Albany, New York

(From the Division of Laboratories and Research, New York State Department of Health)

THE principal, if not the only vector of Rocky 1 Mountain spotted fever in the endemic focus of Long Island, is the American dog tick, Dermacentor variabilis (Say) The epidemiology of the disease thus depends largely upon the distribution, life cycle, ecology, and methods of control of this species It is for this reason that the Division of Laboratories and Research of the New York State Department of Health joined with the Science Service of the University of the State of New York in extending the study that was made by the State Entomologist on Long Island during the summer of 1945 1 The present discussion is a summary of our observations during the summer of 1946, and of reports of similar surveys in other parts of the country

In the Rocky Mountain region, the disease is transmitted by the wood tick, D andersoni Other potential vectors are the Pacific coast tick, D occidentalis Mary, and the Lone Star tick, Amblyomma americanum (L) ubiquitous rabbit tick, Haemaphysalis leporispalustris and the cajenne tick, A cajennesse, apparently at present confined in the United States to extreme southern Texas, have been found to transmit the disease to experimental animals and hence are also potential vectors The life cycles of the Rocky Mountain wood tick2 and of the American dog tick are similar Bishopp,<sup>3</sup> and Smith and his associates, have made extensive studies of the American dog tick, the latter having surveyed the islands off Cape Cod for a period of five years, 1938 to 1942 With few exceptions. our observations on Long Island this year parallel their findings, and I have drawn freely from their publications in this paper

The American dog tick is distributed widely in the United States eastward from the Rocky Mountains to the Atlantic coast and southward to the Gulf of Mexico and the Rio Grande, it is also found on the California littoral There is a tendency to concentration along coastal areas Within a given region there are spatial and seasonal variations in incidence, but certain zones of localiza-Ticks are most numerous along roads, tion exist paths, trails, and animal runs Mice captured at the very edge of a road have been found to be eight times as heavily infested with ticks as those trapped 200 feet back 4 Smith's studies indicate that the range of travel is limited and that the tendency is to remain in a small area throughout the senson There is random movement but the prevailing direction is toward the routes of mammalian travel, where the tick then remains However, even concrete roads are not a barrier to their movement

Tests indicate that the ticks are attracted by the scent of man and mammals. Wooden stakes handled by a person or rubbed on dogs became in fested with ticks, but none were found on unscented stakes or clothes. Apparently ticks do not willfully move toward bodies of fresh water and concentration in such areas is probably due to the presence of animals about water holes. There has been no demonstrated relation between the direction of movement by egg-bearing females and the position of mouse runs.

In considering the life cycle of the American dog tick, probably the most significant facts in relation to Rocky Mountain spotted fever are that the rickettsiae which are the causative agent of the disease are transmitted from generation to generation of ticks by infection of the eggs through the female, and that they are innocuous The next important fact is that to the ticks the ingestion of blood by the adult tick can result in an increase in the number and the virulence of the pathogenic rickettsiae—a "reactivation" of the agent which makes subsequent bites of a partly engorged adult more infectious than The life cycle of the the bite of an unfed tick American dog tick has four states with three host periods during which the tick obtains the blood meal so essential to its subsequent meta-The four stages are the egg, the morphoses larva, the nymph, and the adult

The Adult Tick—Under experimental conditions the adult may live more than two years without feeding. The maximum observed lon gevity is 1,032 days. The adults feed only on the blood of mammals. The dog is the principal host and man is only accidentally infested. Males feed and mate with one or more females intermittently on the host for indefinite periods. The females become engorged with blood in about ten days and then drop from the host to find a satisfactory hiding place in the grass. Depending on the temperature, the female begins to lay eggs in from six to sixty days after dropping.

Eggs—The eggs are laid in compact masses of 4,000 to 6,000 over a period of two to five weeks. After this the female usually dies within a few

days but may live for several weeks. The menbation period varies with the temperature, normally ranging from thirty six to sixty days. Extended incubation tends to shorten the life of the larvae eggs surviving a winter also yield shortlived larvae.

Larrae -The larvae may live for more than a year without a blood meal a maximum longeyity of five hundred and forty days has been noted by Smith 4 The larvae attracted by the odor concentrate along mouse runs and feed on the mice or on other small rodents remaining at tached for about four days Upon full engargement they seek a protected place in the grass in which to undergo their metainorphosis into nymphs Depending on the seasonal temperatures and moisture, the period from dropping to molting varies from ten to two hundred and fifty days In this climatic zone larval activity begins in March or April reaches a peak some time between March and June and then declines as the summer progresses. A secondary peak may occur in August or September and activity ceases in September or October of a normal year Larvae active before July have usually hatched the previous season, the late peaks are due to Lirvae hatched from eggs laid the same season

Numphs -The nymphs have been found to live five hundred and eighty four days without feed ing 4 The engorgement period is from three to eleven days and the period between dropping off the host and molting ranges from twenty four to two hundred and ninety-one days Nymphs molt the same season they engarge but only a few of the resulting adults are active that season Nymphal activity begins in March or April increases stendily until July or August then declines until cessation in September or October Nymphs active before June are those emerging from hibernation those active after June are derived from larvae molting the same season Lake the larvae they feed on small rodents espocially mice, and tend to concentrate along mouse runs

When the adults developing from the molting nymphs are ready to feed, they climb up on the grass or other vegetation and when approached by a possible host become agitated. They cling to the vegetation with their third pair of legs and wave the other legs about prepared to grasp any passing object.

Thus the completion of a life cycle of the American dog took varies with seasonal humidity light and temperature, and with the ability to find liests on which to feed. Temperature dominates the entire cycle affecting activity length of developmental periods and survival. High temperatures accelerate activity and reduce the de-

velopmental periods Smith found a close correlation between temperature and the time required for molting by larvae and nymphs oviposition period, and incubation period of the eggs. Unfed ticks in the early part of all stages are resistant to low temperatures, unfed larvae and nymphs will survive in a temperature of -4 F and adults survive in 0 F and can live through a winter En gorged larvae and nymphs are somewhat resistant to cold but eggs and engorged females are very susceptible Moisture is essential to survival at all stages Periods of drought interrupt hatch ing of eggs and the succeeding moltings are adversely affected by excessive precipitation only if submerged Engorged forms seem to survive immersion better than flat forms Engarged larvae and nymphs have survived five days' submersion in fresh water, larvae have survived one day in sea water and engorged nymphs three Smith found no correlation between rela tive humidity or precipitation and the tick activ ity and development. The seasonal light periods affect the immature stages of the tick. Long and increasing photoperiods are more favorable than short and decreasing ones Long field activity reduces the tick's vitality Very few adults are active more than one season under normal conditions

Hosts -The principal host of the adult tick is the dog but in the absence of dogs a wide variety of the larger mammals has been found to serve as host . On Lond Island we have observed adult American dog ticks attached to deer foxes skunks raccoons squirrels, chipmunks opossums and rabbits and on domestic animals such as the cow and horse. In the Rocky Mountain region and on the islands off Cape Cod the Der macentor larvae and nymphs feed principally on mendow mice. On Long Island however we find that white-footed mice are more frequently the Thus the food of ticks is the blood of mammals and tacks use the available hosts The larvae and nymphs utilize the smaller mam mals particularly small rodents but the adult ticks use these small mammals to a very limited extent. Hence an essential of the distribution of ticks is the joint presence of small rodents such as mice and the larger mammals such as dogs deer and domestic animals. The presence of these mammals in turn depends on the presence of proper and adequate vegetation which in turn is dependent on suitable soils and climatic condi

While birds have been found to be hosts of the rabbit tick, the role of the bird as a host of the American dog tick is not established but it is being extensively studied by us this season If the birds of the region were demonstrated to be

hosts of this tick, it would present a significant epidemiologic problem in migratory birds

Finally, I should like to discuss briefly methods of tick eradication The burning of vegetation will result in at least a temporary reduction in the number of ticks through their destruction and the dispersal of the small rodent population However, with the reappearance of vegetation both the rodents and the ticks will increase in Burning does have the value of destroying the mats of dead grass in which the larval and nymphal forms seek concealment control of the small rodent hosts by poisoning will reduce the incidence of ticks in the treated area during the season following the treatment In this region we have reason to suspect that removal of the principal host of larvae and nymphs would only result in the utilization of other mammalian hosts Eradication of the ticks by this method would destroy most of the local fauna and create a serious ecologic imbalance Smith found that the systematic treatment of all dogs in an area by dipping in solutions of insecticides substantially reduced the number of ticks in the area, but three years were required to achieve the maximum effect

The exact status of DDT in the control of ticks has not been established According to Bishopp. emulsions of 0 5 per cent DDT in a 2 5 per cent soluble pine oil sprayed over infested wooden areas at the rate of 1 to 3 pounds of DDT to the acre destroyed a large percentage of the various stages of ticks, including the American dog tick, the Lone Star tick, and the black-legged tick Ten per cent DDT dust in pyrophyllite applied to grassy areas also gave good results Glasgow and Collins¹ found that a number 2 fuel oil solution containing as little as 0.25 per cent DDT plus 0 0625 per cent pyrethrum and used at a rate equivalent to two quarts to the acre resulted in good control of the American dog tick under experimental conditions They are giving further study to this method DDT is less deterimental to the honey bee than lead arsenate 6 While five pounds of DDT per acre of forest land by airplane dispersion will cause great destruction of nesting birds which probably feed on the toxic insects, two pounds to the acre will not kill the Fish will be killed by concentrations of birds one-half pound to the acre However, there is some reason to believe that lesser concentrations than those harmful to birds and fish may be sufficient to control the American dog tick awaits the results of further studies by a number of investigators, including Dr R D Glasgow and Dr D L Collins of the New York State Science Service, who are studying the problem intensively on Long Island

#### Summary

Observations on the distribution, life cycle. ecology, and methods of control of the American dog tick indicate that the following factors can influence the epidemiology of Rocky Mountain spotted fever

The rickettsiae which are the causative agents of the disease are transmitted from generation to generation of ticks by infection of the eggs through the adult female, the rickettsiae are innocuous to the ticks While climatic conditions alter the length, character, and vitality of the various stages of the tick, there are stages which survive the low winter temperatures in this re-This resistance to cold, coupled with the heriditary transmission of the rickettsiae, results in the perpetuation of the disease from year to On the other hand, climatic conditions which lengthen the stages of development, particularly extended periods of incubation of eggs. tend to produce short-lived ticks

In order to undergo the necessary metamorphoses, the tick must find a mammalian host from which to obtain a blood meal. This results in concentrations of the tick along routes of mammalian travel The presence of mammalian hosts, in turn, depends on a terrain with suitable and adequate vegetation In a highly cultivated terrain the incidence of ticks is decreased, probably by the elimination of flora favorable for attachment of ticks, and to the dispersion of the small rodents and larger mammals which are the essential hosts

The ingestion of mammalian blood by the adult tick can result in an increase in number and virulence of the pathogenic rickettsiae which makes subsequent bites of a partly engorged tick more infectious than the bite of an unfed tick

The fact that the domestic dog is both the principal host of the adult tick and the intimate associate of man makes the possibility of exposure of persons to infected ticks greater than if the principal host were a less closely connected domestic host, or a wild animal

The control of ticks has met with limited success, but extensive preliminary studies with the insecticide, DDT, are promising

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# THE STATE SCIENCE SERVICE AND THE SPOTTED FEVER PROBLEM ON LONG ISLAND

ROBERT D GLASGOW,\* Albany, New York

A S IS well known, there has been for many years an endemic focus of Rocky Mountain spotted fever in the eastern part of Long Island and the center of greatest intensity appears to have persisted in the town of East Hampton

The principal tick vector, Dermacentor variabilis, commonly known as the American dog tick or the Eastern wood tick, is also locally abundant in the eastern part of Long Island, and for this tick the areas of greatest abundance appear likewise to lie in the town of East Hampton

Recently, this tick and the spotted fever situation have become subjects of some newspaper publicity, and the general public both on Long Island itself and in the tributary metropolitan area has become increasingly tick conscious Apprised of the situation, officers of the Long Island State Park Commission at once became concerned about the apparently progressive increase in the incidence of spotted fever and the seeming westward extension of its range, as well as the attendant health hazard to the growing number of users of our Long Island system of State parkways, parks, camping areas, bathing beaches, and other recreation facilities Accordingly, Mr Henry Reppa, assistant general superintendent in charge of maintenance, asked in the summer of 1945 that entomologists of the State Science Serv ice undertake a study of the tick vector and its control They generously offered to place at our disposal laboratory space and living quarters for our scientific investigators considerable amounts of material and equipment, and the services of State Park Commission personnel as needed

Starting after the peak of the tick season had passed, with the assistance of Dr D L. Collins, of our Office of Entomology, we made a preliminary survey of the situation. We also carried out a sense of screening tests with known scancides, and with insectiones which seemed to have potential acancide value in order to find the most promising agents for intensive experimental use in 1948.

With the additional assistance of the Suffolk County Mosquito Control Commission, this project was expanded and technically rounded out in the spring of 1946 through arrangements for the active participation of the State Department of Health Division of Laboratories and Research Dr Gilbert Dalidorf then director of the Divi sion of Laboratories and Research, was much in terested in the Rocky Mountain spotted fover problem, and we were especially fortunate to have Dr John K. Miller of that Division ready to join us in a broad, ecologic study of the situation Again in 1946 as in 1945 laboratory space and living quarters for personnel were generously provided at Montauk Point by the Long Island State Park Commission. Special laboratory equipment including a refrigerator autoclave sterilizer centrifuge and laboratory tables with appropriate auxiliary instruments and equipment, and the services of an electrician and a plumber for their

installation were provided by the Division of

Laboratories and Research

Three men from the State Science Service and two men from the Division of Laboratories and Research have spent the spring and summer at the Montauk Point field laboratory, and other personnel from Albany have participated in the work from time to time. The Science Service personnel are working on the life history habits, host relations and possible control of the tick Dr Miller and his associates are using all available means for making a comprehensive survey to determine the incidence of spotted fever, both of recognized and of possible unrecog nized or subclinical cases in the human population and in various species of domestic animals and wildlife. These two lines of effort are being closely coordinated and integrated in such a man ner as to constitute a comprehensive, ecologic study of the tick and spotted fever complex.

This complex comprises the rickettsial pathogen the tick vector sources of food and of transportation for the various life stages of the tick acceptable and unacceptable alternate hosts of the pathogen, and the physical and other biologic factors of the general enviornment which together govern the epidemiology of the disease. The human element while of dominant importance from the human point of view is a relatively rare phase of a broader pattern

The problem presents many interesting angles Not the least of these is the fact that while the mammal infected with spotted fever dies or acquires permanent immunity upon recovery, the tick host which may acquire the rickettsial pathogen in any of its life stages remains infective throughout the remainder of its individual life Not only this but a female tick infected with Rickettsiae may pass the pathogen on through

<sup>\*</sup> State entomologist, New York State Science Service.

her eggs to her son and daughter ticks, and the daughter ticks in turn, without further source of infection such as taking blood from a mammal in the infective stage of the disease, may pass the pathogen on to still another generation of descendents from the originally infected female tick. Obviously, the tick and not the mammal is the continuing reservoir of the disease

With this relationship in mind, one might wonder why the entire tick population should not eventually become infected, and the disease eventually become more general than it now appears to be Among many other working hypotheses are the following

- 1 Perhaps the tick species is in some degree self-cleansing, with the rickettsial pathogen being passed on by infected ticks only to a portion of their descendants in each generation
- 2 Perhaps local intense epizootics may exhaust the supply of nonimmune mammals, and permit the pathogen to vanish locally, or to lose its virulence

Such hypotheses pose innumerable problems for experimental exploration

The spotted fever problem on Long Island dif-

fers materially from the corresponding problem: Montana, and apparently calls for a different In Montana, with its vast area an relatively sparse population, vaccination of a residents in the spotted fever area should provid a relatively simple and practical solution for th human phase of the tick and Rickettsia complex On Long Island, likewise, vaccination of perma nent residents should be equally effective an practical, though on a much larger scale, bu Long Island is also a recreation area for million of transient visitors from metropolitan New York and vaccination of these hordes of visitors would scarcely be possible, even if acceptable to them For this reason, it seems necessary in the case of Long Island to search further for practical mean of so changing the biologic balance as to reduc and hold the tick population at a point well below the danger level

This objective can be attained only through a better knowledge of the ecologic complex with which we are concerned. The elements of the pattern are the rickettsial pathogen, its tick vector, wild life generally, domestic animals, and fin ally, almost as a biologic accident but more and more urgently with increasing numbers, man

## PUBLIC HEALTH ASPECTS OF ROCKY MOUNTAIN SPOTTED FEVER

ARTHUR T DAVIS, MD, \* Riverhead, New York

What E HAVE now had some 94 cases of this disease in Suffolk County since 1912 Among these, we have had 17 deaths Each year for the last two we have had 11 cases Of the 11 cases so far this year (1946), we have had three deaths The year 1940 was the only one with no reported cases since the disease was first made reportable in 1933

Rocky Mountain spotted fever was endemic only in East Hampton between 1912 and 1934 There were no cases outside of East Hampton Township until after this time, but since then it has been reported from every town Huntington Town this year reported its first case. The disease has definitely travelled down through the South Fork, then center, westward on the North Fork and, finally, on the North Fork to the eastward.

\* Suffoil County health commissioner

We have all talked about the various means of preventing the disease—It is impossible to avoid infected areas, since it is not confined to rural areas alone—In the well-populated village of Port Jefferson there have been cases in two children who had not been out of their own yards—That is also true of several other villages, so staying away from a purticular area does not answer the problem—Second, it is said "wear suitable clothing."—Practically nobody binds his clothing around the wrists and ankles at the seashore—It is just foolishness to suggest it—Other speakers have stressed other means of prevention

I do think that a little more local education of the public would be valuable, especially if most of us would bring to individual patients the fact that they are liable to contract the disease People who are definitely going to work in the area

should be vaccinated

#### DISCUSSION OF THE SYMPOSIUM ON ROCKY MOUNTAIN SPOTTED FEVER

DR HAVEN EMERSON When Dr Brill gave us his clinical impression of the condition which at that time was not identified as being one of the rickettmal diseases it was a matter of perfectly thrilling excitement to the internant Bellevue Hospital The question arose in the New York City Health Department as to what to do when a case of Brill a disease was found. We hunted for the body louse and never found any Brill a disease occurred almost always in the households of well-to-do people who lived a life of immaculate cleanings in which you would never expect to find a body louse. But we had been taught that all diseases of the typhus variety were related to the body louse. We had the same expomence that Zineser did in Boston He had to get the police department to arrest a vagrant so he could obtain a louse for experimental purposes

Because of the lack of entomologic and epidemiologic information, we did all the unreasonable things that health departments are apt to do in the presence of epidemics just as we are doing now in the presence of poliomy chtis It is a misfortune to have it supposed that whenever a disease appears that is theoretically preventable we should do something drastic about it. It should be noted that the health department has only about four resources police authority technical services research, and education. I am interested to see the trend of the remarks today While we are waiting for the entomologists and research students to give us further proof of benefits from sanitary control of environment, we certainly should not use authority One would hate to see a health officer sufficiently bold to require the isolation of patients with Rocky Mountain spotted fever or quarantine of contacts. That is what I mean by exercise of authority Education is constantly and increasingly being availed of and I wonder if the entomologists and others realize how we hang onto their words as to the best thing to do with this disease on Long Island or elsewhere.

What is it that we are going to teach? One thing is inspection of the body periodically. Our children on the North Fork nirely come out of the woods after berry-picking without going into the salt water. I don't know how it matches up with entomologic knowledge, but ticks don't stay on very long in the salt water. There is a good deal of protestion I believe in the use of salt water as a part of the recreational regime which is traditional here on Long Island. I think it is valuable to know how long the tick will stay on a person in the course of a bathing experience in the creeks or bays.

I want to note particularly our interdependence on the childran. You will recall that we got our first intimation of endemic typhus from Dr Brill. Dr Edwards gave us another lead to better understanding of a typhus-like disease, and if you go back into the history of a good many disease of public health significance you realize that the first step toward progress was made by the acute observant clinician at the home bedside or in the heputal

There is a little pamphlet I would refer to which

may be useful to those who are responsible for public action and professional care of patients with communicable duseases. It is Reprint Number 1697 of the United States Public Health Service Reports 1945 sixth edition. It gives in the course of about one page the essential facts of each of some 82 communicable diseases. In spite of the difficulty caused by our changing habits of terminology they have tried to classify the type of infection under tack borne fica-borne louse-borne and mite-borne rick oftsial diseases with their appropriate popular names attached to them. That little pamphlet I believe about be in the hands of everyone interested in communicable disease.

For twenty years and more we have seen that every graduate of the College of Physicians and Surgeons has had it, and we have put it into the hands of all public health nurses. It is valuable not because it has new or strange information, but because it encourages uniformity in the practice of public health. New York State having been traditionally in the vanguard of liberalization of communicable disease control has often modified its practice prior to the publication of the succeeding editions of this little pamphlet.

I believe that public health will progress in this field as it has in others, practically entirely through the process of education and this symposium is just one of the best kind of educational experiences. What we have been exposed to today is one aspect of professional education. It is much more difficult to go out and talk to the laity about these technical matters. It should be realized that health departments are awaiting authoritative teaching from the entomologist, the laboratory student, and the epidemiologist.

DR. Franklin M. Hanger. The physicians of this community are to be commended for the realistic manner in which they are attacking the problems of spotted fever which is obviously ondemic in Eastern Long Island. The eradication of infected ticks seems a large and arduous enterprise and yot much has been learned from these authoritative discussions regarding the opidemiology and prophylaxis of the disease which will be most useful in reassuring and counseling local residents and visitors.

From the clinical standpoint it is important to remember that the chief lesions of spotted fever are in the vascular system. The cutaneous rash thrombotic manifestations, and dysfunction of various organs, such as the brain and myocardium, are probably due in large part to derangements of blood supply. Patients convalescing from this disease should be protected from excessive strain for many weeks, as the lumen of many vessels may be narrowed or occluded long after the acute symptoms have subsided.

One of the most interesting now facts that we have learned today is the proof of the existence of spotted fever in this locality among the dogs — This finding may revise our ideas of the opidemiology of this disorder especially in explaining infections in persons

with no history of tick bite. Careful investigations are necessary to determine if a human can acquire the disease directly from dogs. It is well known that laboratory workers have contracted rickettsial diseases from handling tissue cultures without an intermediate host. It is also known that diseases like psittacosis may be contracted readily from infected birds although they are rarely transmitted from human to human. The physicians who have ample opportunity to observe the natural course of the disease will no doubt ultimately clear up this most important aspect of the problem.

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Progress has also been made in the therapy of spot-The infection is self-limited and all supted fever portive measures should be instituted to conserve and prolong the energies of the patient until a sound immunity develops Adequate fluids are especially important and should be maintained in delinous and comatose patients by parenteral administra-Immune rabbit serum is now available and is indicated at any stage of spotted fever when toxemia Serum, however, is most effective is pronounced when administered early Para-aminobenzoic acid, when begun within the first few days of illness, offers considerable promise as a therapeutic agent not a cure, but if administered at two-hour intervals in 2-Gm doses, it seems to depress the fever level and decrease the toxic manifestations. Its beneficent action is said to depend upon a growth-inhibiting effect on the Rickettsia Only after extensive trial. however, can its true merits be evaluated

I should like to ask Dr Topping if he has seen permanent damage to the brain, heart, or other organs following spotted fever, and also whether he has observed a chronic form of this disease, and whether it predisposes to chronic vascular disease

DR REIDAR TRYGSTAD, Central Islip. Long Island There are certain points, perhaps, which have not been emphasized One is the children children the rash is frequently a papular rash from the very beginning and gives a characteristic feeling on stroking the skin Also, in our cases we have almost always palpated the spleen There is one problem that comes up, and it arose in 2 cases in Central Ishp How shall we make a diagnosis in elderly people who have a fulminating infection? They usually die before serologic studies are positive, or the I believe a biopsy of the skin, even rash appears though no definite rash is present, would give suggestive evidence One should do a splenic puncture and take a blood specimen and inoculate it into one or two male guinea pigs

Regarding Dr Topping's theory that our dogs are infected prior to a known outbreak, I think that should be looked into in all cases

As to the possibility that the disease has always been present in Suffolk County, we know definitely that in this County ten or fifteen years ago all cases were east of Shinnecock—Isn't it more likely, since the first case originated on Gardiner's Island, that the deer there, which previously were imported from the West, were infected, and that one deer swam across and presumably carried the disease into another territory? Local ticks became infected from

one of these imported vectors, and pet dogs subsequently caused more widespread dissemination

DR NORMAN H TOPPING Several questions have been asked The first was, why aren't all of the ticks infected? I neglected to say that of the 3,000 to 6,000 ticks that hatch from the eggs of an infected tick, not all are infected, and with each successive generation in the laboratory, fewer and fewer are infected Parker and others have found it necessary each year to re-establish the virus in the infected tick colony, because the ticks are not capable of infecting enough of their progeny

As to Dr Hanger's question about permanent damage, I have seen only one child with anything that looked permanent About the time of defervescence the child developed postencephalitis similar to that following measles, mumps, or severe virus The child had a blank stare, could not infections hear, and showed all the signs that go with a severe encephalitis The case has been followed for three years, and there has been complete recovery The child comes in every six months for a check-up In the literature, however, there have been several reports of a more or less Parkinsonian syndrome follow ing a severe case of Rocky Mountain spotted fever The more central nervous system symptoms there are during the acute illness, the greater is the chance of having some sequelae However, these are very

How can one make a diagnosis in an elderly patient with fulminating disease where death occurs before the appearance of the rash, or before positive serologic reactions can be obtained? The suggestion made is the one we usually follow, even after death. A small amount of blood can be withdrawn and inoculated into guinea pigs. It is not necessary to pass the infection to other animals. After twelve to fourteen days the guinea pigs can be bled, the serum separated, and complement fixation tests performed. In this way it can be determined whether or not the disease is Rocky Mountain spotted fever

As for the origin of spotted fever and whether it started in Gardiner's Island and then invaded the rest of Long Island, the question is of theoretic interest only, since it is endemic over most of the United States, and we are now getting such interest and knowledge among our practitioners that it is being recognized more and more each year

DR WOLF D SCHMIDT, Smithtown Branch, Long Island In view of the histologic findings, I am wondering whether anticoagulant therapy has any part in the treatment of spotted fever? Also, how long does a tick have to be attached to a person before it can be assumed to have transmitted the disease? Is there any time limit during which cauter ization would be effective in preventing the development of the disease?

DE FRANKLIN M HANGER I could only speculate on the question regarding anticongulant therapy As you know, the lesion of typhus is not unlike that of periarteritis nodosa. I think it is an interesting suggestion, especially for patients with thrombotic tendencies. The problem is whether, with arterits

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and a weak arterial wall, a hemorrhage might not be precipitated by anticoagulants.

DR. NORMAN H TOPPING In reply to the question about the length of time during which ticks must be attached in order to transmit the disease Rick etts who originally did the work, took two groups of guinea pigs, in one group he removed known in feeted feeding ticks at various times, in the other he left them on He reported that between ten and twenty hours of attachment, none of the guinea pigs came down with Rocky Mountain spotted fever After twenty hours or longer all of them did that time Parker and others have fed infected ticks on guinea pigs and noted the results Ricketts I think, was a little optimistic. The safe period it has been found, is somewhere between two and six hours. If the tick feeds longer than six hours the guinea pigs usually develop Rocky Mountain spotted The question of the reactivation of the virus has been brought up Several theorists question whether that is true. One of the theories which is certainly interesting at least is this It is known that the tick probably does not infect through the bite The mosquite has the mechanism to inject but ticks probably transmit the Rickettsia through their feces That also holds for the flea in mumne typhus and the lowe in epidemic typhus. When a tick is placed upon a guinea pig to feed it doesn t pass any feces for some time, usually six ten, or twelve hours This would explain why there is a latent period

Dr. HAVEN EMERSON Isn't that modified possibly by the way the tick is removed? If a tick which may not have begun to discharge feces is crushed during removal, isn t it likely that direct lafection through the skin may occur in a shorter period? I wonder if in the teaching of this, we falled to stress the necessity of gentleness and precision in

removing the tick

DR. NORMAN H TOPPING The contents of the colomic cavity are highly infectious and crushing the tick during removal is a definite danger

One method I have heard of is to put a little collodion on the tick, then they can t get oxygen and will become disengaged. Other methods employ household ammonia todino acctone other aburning eigarctic butt, etc. We say remove the tick treat as if there had been a splinter and wash with alcoholor soap and water.

Dr. James E. Perkins, Deputy Commissioner of Health Albany Can you toll me why we have so few ticks in Upstate New York proper? I think it is a fact, and seems to be confirmed by the geographic distribution of Rocky Mountain spotted fever and by the low prevalence of tularenia as well. I am curious to know whether Dr. Topping or Dr. Glasgow can offer any reason why there are so few ticks of any variety in Upstate New York proper

DR. ROBERT D. GLASGOW. That is one of the things we would like to know ourselves and hope to find out.

DR SHEFARD KRECH There is one phase of this problem that has not been touched upon, and that is the role of the veterinarans. Dr Pontick, of East Hampton has already been of great service in detecting cases in dogs which were thought to be possible

carriers of Rocky Mountain spotted fover and Dr Fischer veterinarian of Suffolk County has also shown a helpful interest. I believe that the medical profession should work more closely with the voterinarians and benefit by their more specialized ax perience. It is obvious that much work lies ahead particularly in the field of animal carriers as possible intermediate hosts.

DR. S BENEDICT FISCHER, DVM I have seen 5 or 6 cases in dogs without laboratory confirmation but I am certain in my mind of the diagnosis of

Rocky Mountain spotted fevor

DR. ALBERT PONTICK DVM We had a number of cases in dogs which have been called Rocky Mountain spotted fever but to date have not had any laboratory reports to confirm the diagnosis. The chain of symptoms has been very similar to that in humans. We shall have to wait until next year or the following for more complete reports, and possibly use a more refined test to aid us in this work.

QUESTION Would Dr Topping discuss insect

repellents for ticks?

DR NORMAN II TOPING There have been very interesting fields studies, one of which is being car ried on in Georgia using DDT in a rather limited area and they intend to continue it over a number of years making periodic tole counts to check the effect. I know as far as the dog tick is concerned DDT does not appear to repel ticks and, apparently does not repel adult ticks as far as the human is concerned.

Dimethylphthalate was found to be effective for the mite in the South Pacific where studies were undertaken in tsutsugamushi disease another rickettsial infection. As for repelling ticks on the human it is simple to make an omulsion of soap and dimethylphthalate so it will stay on even after several washings. The Department of Agriculture has carried on studies in soveral southern states. I am sure that within a few years we will have definite in formation on insect repellents in Rocky Mountain spotted fever because considerable study is being given to that problem.

On ETHEL TRIGETAD Wading River Long Island
One thing that has been mentioned in passing at this
meeting but not sufficiently emphasized is the enor
mous importance of educating the public and par
ticularly the importance of teaching the public to inspeet children for the presence of ticks on their
bodles. I think we doctors could do a great deal if
we would stress this point because the ticks do not
become infectious until they have been feeding for
several hours.

I would like to ask whether any of the speakers have had experience with hyperimmuse human serum. We had one case in Mather Memorial Hospital in a child who was practically moribund. We happened to have in town a woman who had had an attack of spotted fever the previous year she had been given a booster dose of vaccine about two weeks before because her son had an attack of spotted fever for which it was planned to use her as a donor However this was unnecessary as her son had a light attack. We gave the patient a transfusion of

blood from this woman in the ninth day of illness and the improvement was most striking. The child had been comatose, and within a few hours was asking for food. The temperature came down by crisis within twenty-four hours, and the child made a good recovery and went home within two weeks. The transfusion was given well along in the second week of illness, which had been diagnosed six days before

admission as measles The child was admitted four days after the rash appeared, and at the time of admission the tick was still actually on the child

DR FRANKLIN M HANGER It is seldom that one has fresh convalescent serum available for the treatment of spotted fever The results in this instance are so striking that it will surely prompt further trials

### THE CLOSED SHOP AND MONOPOLY IN MEDICINE

We said in our January issue that "failure properly to integrate the general practitioner in our scheme of things would seem to signify a bankrupt civilization". In so far as he cannot be affiliated in some way with our hospital centers of continued education and training he tends to go "underground." This situation is essentially unwholesome, the more so because the implications of such a problem are sedulously evaded, just as though it had no reality, meantime much hypocritical stress is laid upon the indispensability of the general practitioner

This situation has come about, we suppose, because formerly it was possible to care for many very ill persons in the home, in accordance with the general social pattern of things, now it is possible for many very ill persons to be cared for in hospitals—by diplomates, the general practitioner has not followed his patient into the "closed shop," he does not belong to the "union"

To what extent the size and number of our hospitals have been intentionally or unintentionally

limited in "scarcity economy" fashion is anyone's guess, in any case, society is now demanding more and larger hospitals. How do the unions expect to see them manned? It would seem that the diplomate monopolists are due for some surprises

Ironically enough, the beneficiaries of the medical closed shop are not, as a class, particularly sympathetic toward their counterparts in the labor movement Logically, they ought to be staunch supporters of their industrial brethren

The general practitioner will have to save himself, it manifestly won't be done for him, he will have to recapture the status enjoyed by his professional ancestors, for it is in him that the aristocratic tradition of medicine is best exemplified. Can the great figures who created medicine be imagined limiting themselves in plebeian fashion—like unto the factory hand who performs one function on the assembly line year after year? It is perhaps logical, after all, that the medical plebeians of today should be unionized in closed shops—Medical Times, May, 1947.

## ACCELERATED GROWTH IN STATE HOSPITAL POPULATION REPORTED

The upward trend in the population of the twenty-six mental institutions under the jurisdiction of the Department of Mental Hygiene has accelerated during the past year, Dr. Frederick MacCurdy, commissioner of mental hygiene, revealed in June. A preliminary survey of the figures reported as of March 31, 1947, by the department's twenty mental hospitals, five state schools for mental defectives, and Craig Colony for epileptics indicated that the population of these institutions had increased by 1,921 over the corresponding total at the close of the previous fiscal year "These figures," stated Dr. MacCurdy, "indicate that we must soon take measures to implement our extensive building program."

At the close of the fiscal year (March 31) the department's institutions were caring for a total of 105,210 patients, of these, 93,482 were in the institutions, 1,703 were in family care, and 10,025 were on convalescent status, said Dr McCurdy The patient population of the institutions increased by

1,521 during the year, while those on convalescent status increased by 364. There was an increase of thirty-six among those in family care.

thirty-six among those in family care

During the year there were 20,057 admissions (exclusive of transfers) to the twenty-six institutions administered by the Department of Mental Hygiene, an increase of 604 over the corresponding total for the previous fiscal year. Admissions to the state hospitals totaled 18,358, an increase of 578. Discharges from these institutions, exclusive of deaths and transfers, totaled 10,176 patients. It should be emphasized, said Dr. MacCurdy, that the increase in admissions to the state hospitals would have been somewhat greater, were it not for the fact that some veterans were admitted directly to the veterans' facilities.

The five state schools for mental defectives admitted 1,511 patients, exclusive of transfers, an increase of only fifty-one — Craig Colony for epileptics admitted 218, an increase of five over the total dur

ing the previous year

#### BENADRYL A TECHNIC FOR ITS ADMINISTRATION

HERMAN RRINGTEIN, M D and Thomas H McGavack, M D, New York City

(From the New 1 ork Medical College, Metropolitan Hospital Research Unit, Welfare Island)

A REVIDW of the literature concerning the use of benadry! (beta-dunethy laminoethy) benzhydryl ether hydrochlorde) as a chemother apeuto agent for the treatment of the allergic states indicates a great divergence of opinion as to its efficacy and the methods of administration. Thus it has been said that the drug is valueless, or that patients have refused to take their medication because of its disagreeable ande reactions. Among the reasons discovered for such statements we have found that the dosage prescribed has been inadequate, or that there has been fail ure to make necessary adjustments in the dose or the method of administration which would lessen or obviate untoward symptoms.

It is not the purpose here to claim that bena dryl is a panacea for all diseases associated with allergy. Our experiences with the 258 patients mentioned in Table 2 and others, however, have convinced us that it is one of the most promising preparations for the symptomatic relief of allergically related states. It is the present aim to outline a procedure for administering the medication which in our routine has been practical and gratifying, and which it is believed should be videly applicable.

There is sufficient evidence to show that bena dryl possesses powerful antihistamine properties, 1-4 as well as atropine-like and antiacetylcholine effects \*\*1.1\*\*—12 The drug exerts its antihistamine effects in a manner unlike any of the other known antihistamine agents in that it neither neutralizes nor prevents the formation of histamine in the body. There is reason to believe that it produces its effects by causing a block to histamine in the receptor of the shock organ involved.

Benadryl is mildly toxed but not cumulative it does produce unpleasant side reactions in at least half the patients taking the drug. These reactions consist of dryness of the mouth, drown ness, light headedness fatigue, blurring of vision and occasionally nausea and vomiting. The degree of discomfort will vary with the dose as well as the individual. However, tolerance for the drug appears to improve rapidly, so that the symptoms enumerated above frequently disappear within the first twenty four to forty-eight hours, even though the patient continues to take his medication. We have had to discontinue medication in only 5 patients because of these side reactions.

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The question of how much benadryl to pre-

scribe for any given patient is an individual one The desage necessary to produce symptomatic relief will differ for each subject and will often vary in the same individual from time to time For instance, symptomatic relief has resulted from as little as 50 mg a day, while in many instances we have had to merease the dose to as much as 600 mg daily An important factor also to be considered in determining dosage is the condition for which the medication is prescribed For example, we have found that, in general, lesser quantities of the drug are necessary in hay fever than in bronchial asthma There is no fixed rule which applies to all patients nor to any one condition in which benadryl is of fective

#### Procedure

For all adult patients a schedule is prepared in which the initial dose is 150 mg of benadry!\* daily apportioned as noted below. On each successive day the dose is increased by 50 mg until a maximum of 600 mg per day if necessary is reached (Table 1). Patients are told to take their medication after each meal and again before retiring for the night. The schedule is arranged so that the dose is increased progressively late in the day.

Every patient is instructed to stop increasing the dose as soon as symptomatic improvement begins, and to remain on his effective dose for a minum period of two weeks. At the end of that time medication is discontinued. If symptoms recur, the patient resumes treatment with 150 mg or less. If there is no relief with this dosage in one or two days he starts again with the previously effective dose.

TABLE 1 —Sensous for Administration Benadata (Dose Expressed in Milligrams)

Day	Breakfast	Lunch	Supper	Bedtime
1	50	50 50 50 50 100	50 50 60 100	
ē	50	80	50	50
3	60	50	60	100
7	30	80	100	100
š	50 50 50	100	100	100
6	100	100	100 100	100 150
Ŧ	100	100	100	150
ġ	100	100	150	150
ŏ	100	150	150	150
10	150	180	150	150

<sup>\*</sup> Ognarous supplies of this material in capsules of 25 and 50 mg have been made available through Dr. E. A. Sharp, director of clinical investigation, Parks, Davis & Co., whose courtesy is herewith gratefully acknowledged.

### THE USE OF PENICILLIN IN SURGICAL INFECTIONS

A Note of Warning

JOHN H GARLOCK, MD, New York City

(From the Surgical Service of the Mt Sinai Hospital)

THERE is no need to stress the fact that with the advent of the new antibiotics there has been a great change in the therapy of infectious diseases. One need only witness the startling results of the antibiotic treatment of certain medical infections, such as cerebrospinal meningitis, gonococcal infections, bacterial endocarditis, etc., to realize that the prognosis and therapy of many medical infections and some surgical infections have undergone a profound alteration

Enough experience has accumulated since the release of penicilin for civilian use to permit an appraisal of its indications, efficacy, and short-comings in the treatment of many medical and surgical diseases. It is the purpose of this short note to call attention to the fact that the indiscriminate use of penicilin by the physician in the treatment of certain surgical infections may lead to disastrous results for the patient by reason of the fact that penicilin, by its effects, may mask the true progress of the pathologic state for which it is being given

During the past six or eight months. I have seen perhaps 12 or 14 patients who were being treated by the physician with penicillin for surgical infections in the hope that operation could be In every instance, without exception, the underlying pathologic process had progressed steadily, although clinically there seemed to be considerable abatement of the disease instances of acute appendicitis, penicillin had been administered for more than forty-eight At the time of consultation, each patient presented all the evidence of a perforated lesion with diffusing peritonitis, yet they did not seem to be as acutely ill as ordinarily is the case in this late stage of the disease The combination of clinical improvement, equivocal physical signs, and a perforated appendix with peritonitis at operation is indeed unusual and offers considerable food for thought Whether penicillin alters the number or virulency of certain organisms or changes the symbiotic relationships of certain groups of organisms concerned in the initiation of appendicitis is immaterial What is more important is that, in spite of these effects on bacteria, the pathologic process started by these organisms will progress to its natural conclusion, namely, impairment of circulation, localized gangrene of

the wall of the appendix, and perforation — I am sure other surgeons have had similar experiences. It seems to me that the physician who undertakes the treatment of appendicitis by antibiotic remedies assumes a grave responsibility and subjects his patient to the risk of serious complications. It should be emphasized that neither penicillin nor any other antibiotic can supplant surgery in the initial definitive treatment of acute appendications.

In this note I would like to call particular attention to the danger of penicillin therapy in the treatment of acute cholecystitis The majority of the patients already referred to belong in this category Each patient has followed an almost identical course. The physician was called on an average of twelve hours after the onset of pain Fever, frequently chills, some prostration, localized tenderness and rigidity, leukocytosis, and a previous histo - of gallbladder disease were evident in the majority of this group All these patients were in the late fifties or sixties Penicillin therapy was instituted soon after the first visit by the physician, usually in the dosage of 30,000 units every three hours During the succeeding two to four days, there was noted improvement in the patient's general condition, an appreciable subsidence of spontaneous pain, a definite fall in temperature, a decrease in the total leukocyte count, but usually an increase in the polymorphonuclear differential count, and, what is most important, a definite decrease in the area of right upper quadrant tenderness and rigidity above combination will lead the unwary physician to believe that the infectious process is subsiding and that operation will not be necessary That the contrary is more often true is demonstrated by the operative findings in each instance cited above

Every patient presented an acute cholecystitis, some with complete gangrene of the gallbladder, all with pericholecystic abscesses. In no instance was there a free perforation. In a recent case, I suggested penicillin therapy in order to observe carefully what would take place with the patient under observation in the hospital. The chinical course of this man, who was 69 years of age, was exactly as described above. Although the physical signs were minimal after four days of penicilin

therapy, the fever had subsided and the patient was completely free of pain, operation disclosed a perforated gallbladder with a walled-off pericholecystic absecs. Extraperationeal drainage of the gallbladder resulted in an uncomplicated recovery

I could cite many other examples of the ill advised use of penicilin for surgical infections which should have been accorded treatment on the basis of sound surgical principles comes to mind the case of a chronic subphrenic abscess of huge size treated for nineteen months by repeated aspirations and injections of peni cillin solution Simple extraperitorical incision and drainage resulted in recovery in three weeks Physicians lose sight of the fact that the nower antibiotics must be used as adjuvants to sound surgery, rather than as supplanters of surgical therapy It should be emphasized that penicillin frequently will mask the true pathologic course of a surgical infection and will full the physician and patient into a false state of security

In this respect we are in the same position as were the otologists when the sulfa drugs were being used for otitis media and mastolditis. The symptoms of the ensuing mastolditis were so ther oughly masked that an accurate clinical appraisal frequently was impossible. Operation usually disclosed a completely destroyed mastold process

I hope that the indiscriminate use of penicilin will not result in the telling of a story that went the rounds after the advent of sulfamilamide. It was said then of a famous hospital that if a patient did not recover after three days of sulfamilamide therapy following admission to the hospital, a history would be taken and a thorough physical examination performed

Note. Since this article was submitted for publication (October 1946) streptomycin has been added to our anti-blotic armanentarium. Whether the above romarks should include this remedy also, only further experience will tell. I am inclined to the view that streptomycin will fall into the same category as pentelliln. It will not replace surgical therapy where indicated

#### PIG BITE SPECIALIST

Esteemed Editor

For some time I have been intending to write you a letter about a big research problem I have been working on, but for some reason I have not been able to get time for it. This is the time of year that I have to give a lot of attention to my chickens, and I have to give a lot of attention to my chickens, and I have to give a lot of attention to my chickens, and I have to give a lot of attention to my chickens, and I have to give a lot of attention to me shot of the service of the s

sistants, or any kind of flunky to collect the data. (Data is a word for all the cases I have seen, and all the cases I could hear about this someone else has seen, but because I thought this all up by myself it is all called my data.) I have had some help from Ma who copied the Bibliography from some pamphlets that were left in my office by a detail man. Now when I tell you more about this research project you will see that it is very scientific and that I have a lot of controls. (A control is somebody I ddn't use my treatment on because he wouldn't stand for it.) And I have some percentages, a lot of percentages (I was always good at ciphenny), and these percentages have been corrected and the corrected percentages have been corrected until they prove just what I want them to prove. And I am going to have some graphs' just as soon as I find out how they make all those funny little tracks on the graph

paper
Now I will have to stop writing I wanted to tall
you all about this research problem but Mrs Bill
Huggins just called for me to come out to their
place right away Bill is still in the hospital and I
guess is doing right well, but the Missos says the
sow don't look so hot and they are pretty worned

about her

Nour friend
The Country Doctor
P.S.—The sow died of food poisoning and I am
threatened with a malpractice suit.—Anonymous
Wayne Country Medical Bulletin Michigan

# USE OF FIBRIN FOAM IN GALLBLADDER FOSSA FOLLOWING CHOLECYSTECTOMY

Bernard J Ficarra, M D, and Joseph Lionello, M D, Brooklyn, New York (From the Surgical Service of Kings County Hospital and the Hospital of the Holy Family)

ON MANY occasions the surgeon is confronted with distressing bleeding from the gallbladder fossa following cholecystectomy. This is especially true in acute or subacute cholecystitis. A valuable aid in the controlling of this type of bleeding is fibrin foam.

We have employed fibrin foam following cholecystectomy in 24 patients From the use of this foam certain facts have been learned which we believe to be of value In 6 patients the fibrin foam was simply placed in the gallbladder fossa followed by a drain inserted in the routine fashion. It was noted that in these 6 cases there was an excessive serosanguineous exudate which persisted up to the time the drain was removed. This exudate, however, ceased within twentyfour hours following the removal of the drain

In 6 patients we sutured the fibrin foam into the gallbladder fossa and purposefully did not insert a drain. No unusual sequelae were noted in this group. In 18 patients the fibrin foam was sutured into the fossa and a routine digarette drain employed. From this latter group our greatest knowledge was obtained

It was found that if there is any evidence of bile-ozing, fibrin foam should not be employed because the foam increases bile-flow. In 3 patients the bile was golden-brown in color. It persisted for two weeks in 1 patient. The others continued to drain bile for ten and twelve days, respectively. At the time of operation bile-ozing was noted in the fossa but it was minimal. On many previous occasions, without employing fibrin foam, oozing of this type was never troublesome. From this group we have learned that the

TABLE I —RÉSUMÉ OF 24 CASES IN WHICH FIBRIN FOAM WAS EMPLOYED

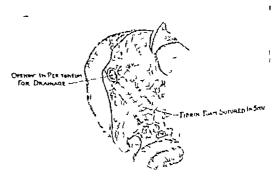
Num- ber of Cases	Pathology	Peri-	Drainage	End
2	Acute		•	Result
_	Cholecystitis	No	1 es	Excessive Sero sanguineous drainage
8	Subscute Cholecystitis	I es	2 No	Uncomplicated postoperative
14	Chronic Cholecystitis	les 4 No	les 4 No	Excessive bile cases

most satisfactory method is to suture the foam into the gallbladder fossa, leave a small opening at the top of the suture line, and insert a drain

In the last 9 patients upon whom a cholecystectomy was performed, this procedure was employed with the utmost satisfaction. On the seventh postoperative day the eigerette drain was removed, and a small sterile catheter inserted in its place for twenty-four hours or more. This enables the drain site to remain patent in the event that an additional accumulation of exudate needs to be eliminated. The catheter is a safety precaution, but it is not an imperative necessity

#### Summary

- 1 Fibrin form was placed in the gallbladder fossa to control bleeding following cholecystectomy in 24 patients
- 2 The ideal procedure is to suture the fibrin in the fossa, leave a small opening at the top of the suture line, and then insert a routine eigerette drain
- 3 It has been found that fibrin foam stimulates bile-flow Therefore, it is not recommended in the presence of bile-oozing
- 4 The proper use of fibrin foam to control slight to moderate bleeding from the fossa following cholecystectomy has been found useful on many occasions
- 5 It is appreciated that no hemostatic agent can supplant meticulous surgical technic which prevents unnecessary traumatic bleeding



Fro 1 Method of suturing fibrin foam in gall bladder fossa

The fibrin foam employed in this study was Celfoam fur nished by the Research Laboratories of the Upjobu Company Kalamazoo Michigan.

#### MULTIPLE PERITONEAL CYSTS SIMULATING CARCINOMA OF THE CECUM

JERE W LORD, JR , M D , New York City

(From the New 1 ork Post-Graduate Hospital)

I NAUCUST 1945 a 53-cear-old white woman was admitted to the heepital with the chief complaint of a right lower quadrant mass of one and one-half years duration. The mass had mereased insize only slightly amount it had first been observed. The patient also complained of fatiguability anomal, increased constipation and intermitten cramp-like pains located in the right lower quadrant of the abdomen. At intervals the stools had been dark in color but not black.

The relevant findings in the past history were first, a bilateral salpinio-copherectomy and supra cervical hysterectomy in 1935 for chronic pelvic in flammatory disease associated with a fibroid uturus second, a right nephropexy in 1938, third a total thyroidectomy for an adenoma of the thyroid in March 1915, and fourth an essential hypertension varying between 180/100 to 210/125 observed for

at least ten years

The physical examination revealed a woman appearing chronically ill with slight pulliness of the eyes and dryness of the akin. The blood pressure was 210/125. There was an well-healed thyroiden to make the composer without palpable thyroid tissue. The heart and lungs were unremarkable. The abdomen was not distended and was the site of well healed right flank and lower mulline scars. In the right lower quadrant there was a firm, slightly nodular movable, nontender mass measuring 12 by 5 cm. Public and rectal examinations were negative except for absence of the body of the uterus.

Laboratory Findings —The red blood count was 4,100 000, hemoglobin was 12.4 Gm white blood count 6 000 differential count normal Unn alysis was negative. The banum enema as reported by Dr William Meyer was Examination with contrast enema shows an imperfection in filling of the occum with an irregular nodular intrusion of its messal border, though small bud like extrusions are also noted in the lateral inferior aspect of the caput. There is also a partial fleoceal Incompetency with the mucosal pattern showing linear striations rather than the transverse valvulae connivent. There is also evident mass resistance about the size of an orange in the right like fosca, the picture suggesting a neoplastic infiltrative lesion with however is not sufficient to result in evidence of gaseous distention or the formation of fluid levels in the small intestine Conclusion Infiltrative lesion with partial stencess involving the caput of the cecum.' (Fig 1)

Acting on the diagnosis of caremoma of the escum, the abdomen was opened through a midright rectus incision on August 10, 1945. In the right lower quadrant the terminal ilcum, cocum, and ascending colon were enmeshed in adhesions and surrounded by innumerable spherical, translucent, thin-walled cysts varying from 1 to 8 cm. in diameter. The larger cysts pressed on the wall of the eccum, which was otherwiso normal. The stump of the cervix was palpated and the remaining viscers and port toncal surfaces elsewhere were normal. Three large cysts were shelled out and many others punctured. The abdomen was closed in layers by inter-



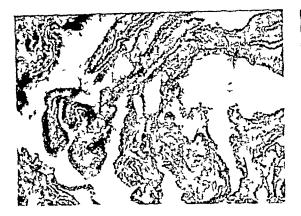
Fig 1 Barium enema, showing the legion of the cocum.

rupted sutures of cotton. Convalescence was uneventful and the patient was discharged from the hountal on the sighth postonerative day.

begins on the eighth postoperative day. Pubologist's Report—Gross Examination. The specimen consists of three monocular spheroidal cysts measuring 55 by 45 mm. 24 by 18 mm. and 14 by 9 mm. in respective diameters. They are of identical construction. They are filled with clear white serous material and have tissue paper thin translucent walls with a glistening internal surface, nowhere showing any thickening or papiliae. Microscopic Examination. Sections of the three

Microscopic Examination Sections of the three cysts show that they are of identical construction. Their wall is a thin lamella of finely fibrillar compact, or loose collagenous connective tissue lined internally a single orderly monocollular layer of either low cuboidal or flattened endothelioid cells. In the wall there are occasional robon-like cells with cylindreal nuclei suggesting the presence of smooth muscle cells. No proliferation or other features of a neophastic process are noted (Figs. 2 and 3)

Follow-up —The patient was placed on 2 grains of desicated thyroid extract daily which caused an elevation of her basal metabolic rate from minus 17 to minus 5 and to plus 5 over a period of four months. This metabolic change was accompanied by increased strength, a gain in appetite, and botter bowel function Examination of the abdomen revealed no



Photomicrograph showing the cyst wall in Fig 2 low magnification

mass or tenderness, the most recent check-up being one year postoperatively

#### Discussion

Dr Alfred Plaut, of the Beth Israel Hospital, was consulted and it was his opinion that the cysts, microscopically, were similar to the case he reported in 1928 1 Histogenetically, Plant favors the hinng cells of the peritoneum as the source of the cysts and, further, that the peritoneal lining is epithelial rather than endothelial in nature He called the lesion "benigh cystic serosaepithelioma of the peri-

In his discussion Plaut adds "all parts of the peritoneum have been found as the seat of the cysts, the omentum majus being the site of preference The disease is more frequent in children and in young persons, but it has been found ac-



Same as in Fig 2, in high-power magnifi Fig 3 cation

cidentally in old people at autopsy The majority of cases (perhaps from 70 to 75 per cent) occur in The condition may be congenital Sometimes new cysts form after operation. Some patients apparently are cured " Although the condition, multiple peritoneal cysts, is unusual, the case described in this paper apparently is the first one to be reported in which a carcinoma of the cecum was simulated both clinically and radiographically

#### Summary

A case of multiple peritoneal cysts in a 53-yearold white woman, clinically and radiographically simulating carcinoma of the cecum, is reported

55 EAST 92ND STREET

#### Reference

Plaut Alfred Arch. Path 5 754 (1928)

#### NEW ACTION ON E M I C PLAN ANNOUNCED

Recent action by the House of Representatives and by the Senate provides that the Emergency Maternity and Infant Care Program shall be in the process of liquidation on and after July 1, 1947, but, regardless of the date of application, all Emergency Matermity and Infant Care services will be provided to any woman or the offspring of any woman shown to have been eligible as of June 30, 1947 Thus the following services under the EMIC Program will be provided on and after July 1, 1947

The completion of all maternity and infant care for wives or infants for whom initial care was

authorized prior to June 30, 1947

Maternity care authorized after June 30, if the mother was eligible under the program as of June 30, 1947, even though she may apply for care subsequent to that date

Infant care authorized after June 30, 1947, if the mother or infant was eligible for care or received care under the program as of June 30, 1947 For example, if the wife of an enlisted man in the eligible pay grades became pregnant before June 30, 1947, she would be eligible to apply for and receive services under the EMIC Program until six weeks postpartum, and her infant would be eligible for service provided under the program until one year of age

#### CHRONIC RECURRENT SUPPURATIVE PANNICULITIS MIGRANS

ROBERT G LIVINGSTONE, M D Boston, Massachusetts

(From the Medical Department, Memorial Hospital New York)

A SYMPTOMATIC suppuration arising primarily within the subcutaneous tissues is a clinical entity of unusual occurrence which apparently has not been described previously. Note of the presumably sterile liquefaction of fat occasionally associated with Weber-Christian's relapsing februle nodu lar nonsuppurative panniculitis; has been recorded elsewhere,2 and abscess formation localizing in this site as a complication of obvious regional inflamma tory reaction or of recognized systemic disease has been a matter of common observation in many other instances. The recent discovery of a chronically recurrent migratory panniculitis marked by suppu ration and attributable to no determined causative factor is presented therefore, for further considera-

#### Case Report

A white woman of Polish descent, aged 21 years was first seen August 14, 1945, because of a localized painless swelling of about six weeks duration on the left thigh.

No events in the family history or in the past history, except for certain observations directly related to the immediate complaint, were found to be of notoworthy significance. About five years proviously a painless swelling as large as a man s hand had been discovered incidentally in the soft tissues of her lower back. Heat was applied locally by means of wet compresses, and spontaneous rupture of the swollen mass, occurring shortly afterwards, was attended by the discharge of a large amount of "yellow pus. The resulting sinus closed over promptly, and the area about the sear soon assumed its normal characteristics. Some time later a similar swelling appeared on the left lower leg, gradually interested. Increased in size, and then became quite soft. Treatment by diathermy was administered by the family physician with no apparent relief. Spon taneous rupture finally occurred, and complete healing of the area promptly followed. At various times thereafter comparable swellings were discovered in many areas of the body Payored sites, however seemed to be the scalp the back, the inframammary region, and the legs. Not infrequently certain swollen areas were seen to disappear without preliminary rupture, but no symptoms other than alight restriction of motion or occasional local tenderness of minimal degree were ever experienced.

Aid was sought from a number of physicians throughout the ensuing three-year period, and eventually at physical examination a diagnosis of cancer arming in the soft parts of the left thigh was clinically suggested Roentgen irradiation was accordingly administered to the area until desquamation occurred but permission for amputation at the hip which then was strongly recommended, was rejused Biopsy by excision from the area was afterwards per formed, but no definite opinion was said to have been offered at histologic examination of the specimen. Gradual regression of the swelling subsequently took place, and an interval of apparent freedom from discase, almost two years in duration intervened. Marriage followed, though pregnancy did not occur and the earlier reference to cancer was forgotten A recurrent painless swelling was then discovered on the back of the left thigh. As it increased in size an awakened fear of cancer quickly grew to certainty in her thoughts and she became exceedingly upeet, lost her desire for food entirely and no longer was able to sleep at night. A weight loss of almost 30 pounds occurred and she again sought hedical advice. At examination she was found to be a thin fairly

well-developed white woman, cooperative and free from pain but obviously distraught. Her weight was 90 pounds. The blood pressure in both arms was 100/60 Small well-bested drainage scars surrounded by a narrow zone of subcutaneous atrophy were present on the occipital area of the scalp in the left inframammary region and in several areas over the left upper and lower legs. A small soft node was palpable in the apex of the left axilla. On the pos-terior aspect of the left thigh overlying the junction of its upper and middle thirds, was a soft fluctuant, nontender mass about 10 cm long, 6 cm. wide and 2 cm thick. No other physical abnormalities could be found.

An aspiration blopsy of the mass was performed, and a large amount of thick, creamy red-brown liquid was obtained Immediate smears showed pus on microscopic examination, and subsequent pus on microscopie examinatori, and succedirent cultures yielded a pure growth of nonhemolytic Staphylococcus aureus Other laboratory studies disclosed a hemoglobin level of 62 per cent (8 6 6 m. per 100 cc.), a red cell count of 8 6 million, a white cell count of 5 6 thousand, and a sodimentation rate of 28 mm. per hour The differential white cell count of 50 millions of 50 mil count showed 82 per cent polymorphonuclear cells, 6 per cent moncoytes, and 14 per cent lymphocytes. The urine was normal except for a slight trace of albumin. Roentgenographic examination of the chest revealed no evident abnormalities.

Return to the family physician was advised, and the intramuscular administration of penicillin in does of 20 000 units every three hours for a period of two weeks was suggested. Therapeutic does of liver extract and of a multivitamin preparation were

recommended as supplementary measures

Contact with the patient was again established February 6 1946 at a follow-up examination Rapid improvement without drainage of the abscess had occurred under the course of treatment thus prescribed, and no recurrence of the swellings had been noted. A weight gain of 161/2 pounds in the A weight gain of 161/s pounds in the intervening six month period had been attained No physical abnormality other than a nontender area of subcutaneous atrophy measuring 11/2 cm in length 1 cm in width, and overlying the anterior aspect of the lower third of the right lower leg could be found. Laboratory examination of the blood disclosed a hemoglobin level of 87 per cent (12.0 Gm per 100 cc.) a red cell count of 4.8 million, and a white cell count of 18 0 thousand. The differential white cell count showed 80 per cent polymorphonu-clear cells 2 per cent cosinophilic cells 3 per cent monocytes, and 15 per cent lymphocytes. The urine was entirely normal. Tests for brucellosis and for infection by tubercle or the typhoid group of bacilli were negative.

#### Comment

The features thus described in this disease have not been recognized as manifestations of any other pathologic condition. Tuberculous "cold abscesses" have been characterized chincally by the chronicity of their course, by their prolonged healing phase, and by the associated findings of fever, leukocytosis, or evidence of focal or primary infection elsewhere. Most other diseases seem to be eliminated from consideration here by the absence of evident systemic manifestations or local inflammatory reactions. The gratifying clinical response achieved through recourse to penicillin administered in therapeutic doses, also observed in a recently reported case of

relapsing febrile nodular nonsuppurative pannicultis where penicillin was likewise utilized, may have been fortuitous or may have been the result of a specific action of this agent. For the present the descriptive term "chronic recurrent suppurative pannicultis migrans" is suggested for this clinical syndrome.

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#### EPHRAIM McDOWELL AND OVARIOTOMY

The story of the first ovariotomy, performed in December, 1809, in Danville, Kentucky, is a familiar one to most Americans. We have read many times of the courage and endurance of Mrs. Crawford, the patient, and of the skill and daring of the surgeon, Ephraim McDowell. For twenty-five tense minutes, McDowell proceeded with an operation which he knew to be a hazardous experiment, he knew also that failure would probably result in the destruction of his professional reputation. With no precedents to guide him, with no aid from anesthesia or asepis, with none of the elaborate paraphernalia of the modern operating room, he depended solely upon his own cool judgment and his accurate knowledge of anatomy. Twenty-five days later, Mrs. Crawford returned to her home, able once more to resume her accustomed routine.

Of the many stories told about McDowell's history-making operation, those that describe an indignant mob gathered at the house at the time of the operation, those that say he performed the operation elsewhere than in his own surgery, those that represent him as seeking to be spectacular are decidedly apocryphal.

At the time of this famous operation, Ephraim McDowell, Virginia-born, Kentucky-bred, and Edinburgh-trained, had been in practice about fourteen years and was a respected member of his small community

His closest friends described him as a silent, phelgmatic man. His accomplishments grew, not from a desire for recognition or acclaim, but from the ingenuity, resourcefulness, and courageous attitude developed in him by long practice under the stern conditions of the frontier. He had derived inestimable inspiration, also, from the teachings of John Bell at Edinburgh, and it is interesting to note that both Bell and McDowell were made unhappy during the latter part of their lives by the small-mindedness and jealousy of their contemporaries and colleagues

It would seem that great achievements in medicine, such as McDowell's ovariotomy, frequently follow a definite pattern. A desire for achievement, the courage and energy necessary to perform a daring experiment, and inspiration, usually acquired from an outstanding preceptor. McDowell's teaching had been adequate, he possessed courage and ingenuity, and he proceeded with great deliberation to

perform his task. He was prevailed upon to report his first three cases, however, only by much persuasion and after a lapse of seven years. Such caution and deliberation are virtues in medicine, all too often neglected today.

McDowell's pioneering effort carned for him the title, "father of abdominal surgery" He was followed in America by other courageous men, such as Nathan Smith Goldsmith, and Rogers duction of anesthesia in 1846 initiated a second epoch in the history of ovariotomy, the operation was no longer a novelty, but a common proceeding Nevertheless, there continued to be long debates pro and The Atlee con, and not inconsiderable feuds brothers (1843-1883) of Philadelphia became the One of them. great proponents of ovariotomy Washington L Atlee, in spite of his skill and renown, was forced to deliver an address revealing the indignities to which he had been subjected by other surgeons One of his colleagues, on passing his house on Arch Street, said, "There lives the greatest quack in Philadelphia" Another remarked, "Tell Dr Atlee that I will not meet him in consultation because he undertakes to perform operations not recognized by the profession

In spite of such opposition the practice of performing ovariotomy continued to spread in the United States and abroad Cazeaux, in France, for six months had a battle on his hands in regard to the treatment of ovarian tumors, opposing him were such great names as Velpeau, Cloquet, and Trousseau Most of the German school favored the operation, but even a few distinguished German surgeons continued to speak of it as sheer murder Dr Emiliani of Bologna, Italy, may perhaps be credited with being the first European ovariotomist\* and second in the world to McDowell, in 1815 he removed an ovarian tumor 9 by 5 cm from a 26-year-old woman, a baker's wife of "lymphatic temperament" The patient survived not only the operation but also the blood-letting, tartar emetic, hemlock, and other remedies, and thereafter produced six children in undaunted succession!

ROBERT N CREADICE, M D Duke Hospital,

Durham

\* A German named Chrysmar may possibly have priority
over Emiliani

<sup>-</sup>North Carolina Medical Journal, May 1947

## WERNICKE'S DISEASE REPORT OF CASE WITH RECOVERY AFTER FEVER OF 108 F

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(From the Department of Psychiatry Syracuse University College of Medicine)

In 1881 Wernickel described what he called 'acute apportor hemorrhagio policencephalitir" and reported his 3 original cases. He considered the condition to be an acute inflammatory process similar to acute policiny clitis. The pathologic changes which he noted were focal petechial hemorrhages symmetrically located in the walls of the third ventricle, in the gray matter around the aqueduct of Sylvius, and in the gray matter of the floor of the fourth ventricle

Since that time a considerable number of such cases has been studied and it has been recognized that the lesions are not strictly inflammatory Gamper' in 1928 stated that the pathologic changes consist of a curiously selective distribution of focal lessons throughout the gray matter of the brain stem. These include hyperomia (at times with small homorrhages), vascular proliferation a vary ing degree of glial proliferation absence of inflamma tory infiltration, and relatively alight evidence of damage to the nerve cells. The lesions are localized in characteristic fashion most prominently in the mammillary bodies, less constantly in the other hypothalamic and thalamic nuclei. In the mid brain, the periaqueductal gray matter particularly the oculomotor nuclei, are involved and this gray matter destruction continues down into the floor of the fourth ventricle in the hind brain words, the lesions extend throughout the brain stem, though minor involvement has been noted in the cerebral cortex.

Of Wernicke s original 3 cases 2 were of chronic alcoholics. Throughout the years since then the association of this disease entity with alcoholism has been emphasized strongly On occasion alcohol has been considered the most important causative agent. In the past fifteen years, however more emphasis has been placed on the incidence of this ailment in nonalcoholic patients with the result that a far better understanding of the underlying metabolic disturbances has been reached. The general trend consequently has been away from the older assumption of direct toxic action by alcohol on nerve tissue, and more in favor of vitamin deficiency precipitated by many conditions including the chronic ingestion of alcohol. The vitamin deficiency may be due either to an inadequate diet, or to inadequate absorption associated with gastrointestinal difficulties or as is often the case in alcoholism to an increased vitamin need even in the presence of a balanced diet, as a result of the high calone value of the alcobol ingested.

Campbell and Biggart\* in 1939 described 12 cases of which only 1 was associated with alcoholism

Their patients ranged in uge from 31/1 to 68 years and suffered with gastric carenoma, chronic dyspepsia with gallstones, pernicious anemia anemia following bowel resection for tuberculosis, vomiting of pregnancy, bronchiectasis chronic pyosalpinx, and whooping cough. In some of these cases Wernicke's encephalopathy was an unexpected finding on routine examination of the brain and the authors expressed the belief that it was frequently missed both clinically and at autopsy

Other reports have described this condition in association with recurrent carcinoma of the uterus chronic gastritis, Hodgkin's disease pulmonary abseces, malaria, scurvy nutritional deficiency and malautrition associated with depressive psychosis. The clinical features of this illness vary to a certain extent and the predominance of one or another of the usual signs or symptoms has been thought to be dependent upon the rolative deficiency of one or another of the vitamin factors. Particular importance has been placed upon thiamin chloride and nicotinic acid.

The most frequent and the most important group of focal neurologic manifestations are the oculomotor disturbances. These include pupillary abnormalities, paralysis of conjugate eye movements diplopia strabismus, and nystagmus. Disturbances of consciousness are also prominent and include drowsness, coma, apathy excitement and delirium. The symptoms of Korsakow's psychoels with disorientation, memory loss, hallucinations, and confabulations frequently are present.

One also sees changing rigidities of the limbs ataxia, visual impairment accompanying optic neurius, and evidence, very often of an associated peripheral neuritis. Spinal fluid changes are notably not significant.

Jollife, Wortls and Fein' reported in 1941 27 cases of Wernicke's syndrome. They emphasized that a combination of several nutritional deficiencies was affecting the nervous system and that the syndrome need not necessarily be complete in any given case. Among other conclusions, they felt that the opthalmoplegic symptoms were specific evidences of thiamin chloride deficiency that these oculomotor palses frequently were accompanied by peripheral neuropathic changes, and they confirmed the thesis that smaller amounts of thiamin are necessary to prevent the policencephalopathic changes than are necessary for antineuritic action.

There has been an occasional report in the litera ture of recovery from this illness. The patient here described is an example of such a recovery

#### Report of Case

The patient was a 37 year-old married man, an intemperate drinker for many years, but more

Presented at the New York State Department of Montal Hygians, Upstate Interhospital Conference Syracuse Psychopathic Repital, April 23, 1946.

markedly so in the months just prior to his admission to the Psychopathic Hospital He had always been in good health except for hypertension of

uncertain duration

For two months prior to his entry to the hospital, considerable weight loss had been noted several days preceding admission, he had had a cough which was being treated at home by a local The patient, however, repeatedly left his bed to look out the windows, referred to people outside who he claimed were looking for him and said he saw "ghosts flying by" He believed someone was drawing blood out of his body, described electric wires over the floor and on his person, and expressed ideas of his wife's infidelity Finally, he drove away from home, gave large quantities of money to strangers, and after he had removed the wheels from his car, arrangements were at last made for his hospitalization At the time of admission, he was confused and disoriented, very excited and assaultive. He spoke loudly about his hallucinations, both visual and auditory. He described imaginary men and animals about him

One day later, his temperature became markedly elevated and he became semicomatose, appearing to Physical review revealed a fever of be in extremis 105 F, rising shortly afterwards to 108 F Pulse was 130 Respirations were 30 His heart was not enlarged, the sounds were muffled Blood pressure was 138/80 Dullness to percussion and moist rales were noted over both lung bases, although lung ev-His abdomen and pansion was bilaterally good genitalia were unremarkable Transient inconti-

nent diarrhea was present

Neurologic examination revealed semicoma, moderate nuchal rigidity, and negative Kernig signs. The pupils were equally constricted and reactive to light. Fundi and disks were normal in appearance Eve muscle movements were markedly dissociated. with one eye wandering independently of the other Pyramidal tract functions were normal, but a cogwheel type of rigidity was noted in both arms other neurologic abnormalities were apparent at the

Blood Wassermann and Kahn tests were found strongly positive, although it was later determined the patient knew nothing of luctic infection and had received no treatment Spinal fluid Wassermann and Kahn tests were negative. At the height of the illness the spinal fluid was clear with 7 cells, total protein of 32 mg, globulin was negative, gum mastic, and colloidal gold tests were negative Spinal fluid sugar and chlorides were not decreased Type 10A pneumococci were isolated from the sputum but blood culture and spinal fluid smear and culture revealed no organisms Blood count indicated a hemoglobin of 91 per cent Red blood cells were 4,860,000 White blood cells were 11,050 with 57 per cent polymorphonuclears, 18 per cent lymphocytes, 24 per cent monocytes, and 1 per cent basophils The urine revealed a persistent trace of albumin and occasional pus cells Fasting blood sugar was 130

Penicillin was administered After the patient had received 150,000 units, his fever reached 108 F At this point, the previously described neurologic signs were noted and the diagnosis of Wernicke's syndrome was made Huge amounts of thiamin chloride, nicotinic acid, and ascorbic acid in several hundred mg doses were administered three times a day intravenously in conjunction with saline and glu-Other vitamin B complex factors were given

intramuscularly

The response of the patient to this vitamin, saline, and fluid therapy, along with penicillin, was rapid and dramatic In twelve hours, the temperature was down to 100 F and consciousness and rational behavior had returned after he had apparently been on the verge of death Slight confusion gradually The delusions did not return and he completed a remarkable recovery In view of the blood Wassermann reaction, the penicillin was continued to a total of 2,500,000 units

Two weeks after admission, the patient displayed a dulled emotional tone and the suggestion of a masked facies The remainder of the neurologic examination was negative except for evidence of a localized peripheral neuritis He had a flaccid paralysis of the deltoid muscle and absent biceps reflex on the right Spinal fluid at this time was still

negative throughout
This patient, it is felt, displayed the signs and symptoms of the Wernicke syndrome, evidenced predominantly by clouding of consciousness, opthalmoplegia, and rigidity It occurred in association with a respiratory infection and in the presence of other evidences of a vitamin deficiency state, namely, alcoholic delirium tremens and peripheral neuritis recovery was due, in large part, to prompt and adequate vitamin therapy

718 East Jefferson Street

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#### SUMMERTIME

With the vacation season approaching we are in our usual dilemma on whether to stay home as we would prefer, go to the seashore as the wife and kids would like to do, or make a quick tour of our relatives as duty would have us do Something tells us we will be going to the seashore

Now that the vaccination epidemic is over, with its sore arms and extravagant tongues, we'll look to the day when people will be immunized to whatever can be positively and safely done at reasonable intervals of time to maintain their immunities But will we see that time? When did you have your last previous smallpox vaccination, Doctor?

Smallpox, diphtheria, influenza, Poliomyelitis, measles, and gout, So long as summer comes after winter, We'll go fishing wherever there's trout -Westchester Medical Bulletin June, 1947



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# DEPARTMENT OF MEDICAL CARE INSURANCE

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Standards for Approval by Medical Society of the State of New York of Voluntary Nonprofit Medical Care Plans in New York State

Local Approval

1 Approval of the County Medical Society in

whose area a plan operates

2 In the event a county society does not approve a plan, a special committee of three members be appointed, one by the plan, one by the county medical society, and one by the Medical Society of the State of New York, to investigate and study the reasons for withholding approval

3 If, in the opinion of a majority of the committee, after consideration, approval will be granted

to the plan.

#### Professional Control

1 The governing body must contain a majority of physicians

2 These representatives shall be members of and recommended by the Medical Society of the

State of New York

3 The medical profession is to assume responsibility for the medical services included in the bene-

#### Free Choice of Physician

1 There shall be no regulation which restricts the choice of a qualified doctor of medicine in the locality covered by the plan, who is willing to participate and render service under the conditions established

2 The method of rendering service must retain the personal, confidential relationship between the

patient and physician

#### Subscriber Benefits

Subscriber benefits may be in terms of cash and/or service units

#### Claim Payments

1 When care has been rendered by a participating physician and claim filed for such care, payment shall be made direct to the participating physician When subscriber has paid the physician, then payment may be made to subscriber upon presentation of a receipted bill This method of payment should be discouraged and should apply only in instances where subscriber has paid the physician

2 When care has been rendered by a nonpartici-

When care has been rendered by a nonparticipating physician and claim filed for such care, payment shall be made direct to the nonparticipating physician or to the subscriber upon presentation of

receipted bill

#### Underwriting

1 Subscriber premium rates should be adequate to provide for the benefits offered and the risks involved in the contract

2 Plan should be organized and operated to provide the greatest possible benefits in medical care to

the subscriber

3 All plans shall conform with state statutes as set up under the New York State Insurance Department with due consideration for earned premiums, administrative costs, and reserves for contingencies

#### Enrollment

Enrollment procedures shall be on a sound basis

so as not to expose the plan to adverse selection

It is recommended that enrollment be offered to
individuals at the earliest possible date that experi-

ence of the plan warrants

#### Promotion

Descriptive folders and all promotional material shall state clearly and accurately the benefits offered by a plan, and also in the same manner, exclusions in the contract

#### Reports

All plans which have received approval, or are seeking the approval of the Medical Society of the State of New York, shall submit quarterly reports on forms provided for that purpose to the Bureau of Medical Care Insurance of the Medical Society of the State of New York

#### Duration of Approval

Approval by Medical Society of the State of New York shall be for a period of one year, at the end of which, review of all plans will be made by an appropriate committee of the Medical Society of the State of New York, to determine eligibility for renewal.

#### Comment

The Subcommittee on Medical Expense Insurance of the Council Committee on Medical Economics of the Medical Society of the State of New York has felt for some time that New York State voluntary nonprofit medical care plans should conform, in their general operation and setup, to certain requirements, in order to be eligible for approval by the Medical Society of the State of New York. The above standards were drafted by the Committee approved by the Council and adopted by the House of Delegates of the Medical Society of the State of New York at its annual session in May, 1947 They conform in general to the outline of requirements of the Council on Medical Service of the American Medical Association for approval of such plans by that body, with other necessary additions that were deemed advisable

The purpose of the standards is to maintain medical control, preserve the established doctor-patient relationship, and aid in accurate promotional material. The filing of quarterly reports by each plan on membership, claims, financial status, etc., with the Bureau of Medical Care Insurance of the State Society will permit compilation of statistical statements and aid in the establishment of benefits and premiums under sound underwriting principles.

The six plans operating in New York State are approved by the Medical Society of the State of New York and subsequent approval will be granted annually, following a study and review of each plan's adherence to the standards, by an appropriate committee of the State Society

It is the feeling of the Medical Care Insurance Bureau that these standards will maintain and further promote the voluntary nonprofit medical care movement and assure continued benefits to the public and the doctors



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COLUMBUS INDIANA

# NECROLOGY

Malcolm Campbell, M D, 71, of New York City died on June 1 He was professor of gynecology and former president of the faculty of the New York Polyclinic Medical School and Hospital

Dr Campbell was graduated from the Medical College of Virginia in 1901, and served his internship at the New York Polyclinic Hospital. He was a fellow of the American College of Surgeons and of the International College of Surgeons He was a member of the American Medical Association, the New York State and County medical societies, the National Gastroenterological Society, the West Side Clinical Society, and the Medico-Surgical Society

Samuel B Close, M D, of Gouverneur, died on June 3 at the age of 90 A gynecologist, he was one of the oldest practicing physicians in the State, having conducted a full practice for fifty-five years and a limited one for the past five He was graduated from the New York University, College of Medicine,

in 1885

Dr Close was secretary of the St Lawrence County Medical Society for fifty-one years and

honorary secretary for the past nine years

Clarence V Costello, M D, of Rochester, died May 31 in Beverly Hills, California, at the age of 60 Retiring in 1941 after 35 years' medical practice, Dr Costello was a former president of the staffs of St Mary's and Monroe County hospitals, in Rochester He was a graduate of the Catholic University, Washington, and the medical school of the University of Buffalo Dr Costello was a fellow of the American College of Surgeons and a member of the National Society of Medical Librarians and the Association of Railway Surgeons

Jacques Goldberger, M. D., 58, of New York City and Saratoga Springs, died on June 5 A graduate of Budanest University in 1911, Dr Goldberger came to the United States in 1939 from Kralovv Vary, Czechoslovakia He practiced medicine in New York City and Saratoga Springs, and was the author of many medical papers and several books published in Europe and this country. He was a member of the Saratoga Spa medical staff, the American-Hungarian Medical Society, the New York Academy of Science, and the State and County medical societies

Charles W Lynn, M D, of Bradenton, Florida, and formerly of New York City, died on June 4 He was 69 years old For forty-four years Dr Lynn was an official of the New York City Health Department, becoming a school inspector in 1901 He was also assistant registrar in Queens and Manhattan, and a founder of the West Side Tuberculosis Clinic He was a graduate of the College of Physicians and

Surgeons, Columbia University, in 1899
Leroy P Van Winkle, M D, of Port Jefferson,
Long Island, died on June 8 He was graduated from the Long Island College of Medicine in 1903, and interned at the Knickerbocker and Lying-In hospitals in New York City Dr Van Winkle was consulting roentgenologist at Greenpoint Hospital in Brooklyn and Huntington Hospital, Huntington, Long Island, visiting roentgenologist at Central Islip State Hospital and at Mather Memorial and St. Charles hospitals in Port Jefferson He was a member of the Brooklyn Roentgen Ray Society, the American Medical Association, and the New York State and Suffolk County medical societies

#### MULTIPLE SCLEROSIS GROUP MAKES FIRST RESEARCH GRANT

The first grant made by the Association for Advancement of Research on Multiple Sclerosis, Inc. for specialized research on multiple sclerosis, a crippling disease the cause and effective treatment of which has baffled medical men for more than a century, was announced recently by Carl M Owen, president of the Association

"This grant," Mr Owen said, "is for \$64,350, and will cover three years of important research in the field of allergy in connection with multiple sclerosis Research provided for in the grant will be under the direction of Dr Elvin A. Kabat, well known for his research in specialized fields of medicine, both before the war and in important phases of medical research for the US Army during World War II"

Dr Kabat is assistant professor of bacteriology at

He will conduct the major Columbia University portion of his work on multiple sclerosis at the Columbia University, College of Physicians and Surgeons, and at Neurological Institute of New York.

In connection with a plea by the Association that all sufferers from the disease write of their cases to AARMS, New York Academy of Medicine Building, 5th Avenue and 103rd Street, New York 29, New

York, Mr Owen added
"Public recognition of the fact that individuals all over the country can now assist science in combating a crippling disease is an important factor in the fight against multiple sclerosis. I hope that people throughout the United States will assist the Association in its work by reporting to it all the facts they know about their own cases or those of relatives and friends"

#### CORRECTION

In the "Revision of Fee Schedule" published by the Department of Workmen's Compensation in the June 1 issue, page 1300, the paragraph 'Five per cent discount for payment of bills within thirty days will be rescinded on bills for services rendered after

June 1, 1947" should read as follows

Five per cent discount for payment of bills within thirty days will be rescinded on bills ren-dered after June 1, 1947" (The corrected matter is in italics )



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### WOMAN'S AUXILIARY

### TO THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

#### Mrs Kice President-Elect of National Auxiliary

THE membership of the State Auxiliary, the Executive Board, and Mrs Harry F Pohlmann, Auxiliary president, extend sincere congratulations to Mrs Luther H Kice, of Garden City, New York, on her unanimous election to the office of

president-elect of the National Auxiliary at the National Auxiliary Convention in Atlantic City Mrs Kice brings great honor to New York State, and she is pledged the complete support of each Auxiliary member

County News

Allegany The members of the newly organized Auxiliary were entertained recently by the Allegany County Medical Society at Still Meadows After the luncheon an election of officers was held at the home of Mrs E Stanley Webster in Friendship Officers elected were Mrs Webster, president, Mrs Loren Bly, of Cuba, vice-president, and Mrs L H Benedict, of Wellsville, secretary and treasurer At the July meeting of the Auxiliary, in Cuba, a constitution will be drawn up

Officers were elected at the lunch-Chautauqua eon meeting of the Auxiliary on June 9 at the White Inn at Fredoma They are president, Mrs Van S Laughlin, of Westfield, vice-president, Mrs Calvin Torrance, of Jamestown, treasurer, Mrs Ralph Randell, of Jamestown, recording secretary, Mrs Harold M Childress, of Jamestown, and corre-sponding secretary, Mrs Robert Northrup, of

Westfield

Mrs Benjamin Custer, of Fredonia, was in charge of arrangements Mr Robert M Laughlin, son of Mrs Laughlin, the president, sang a group of solos Guests of honor were Mrs William Rennie, of Buffalo, State councilor of the Eighth District, Mrs Arthur L Bennett, of Buffalo, president of Eric County Auxiliary, Mrs Walter G Hayward, of Jamestown, State charman of public relations, and Mrs Lee R Sanborn, of Angola, State chairman of press and publicity

Erle The Annual Play Day, final meeting of the

Auxiliary before the summer recess, was held on June 17 at the Niagara Falls Country Club in Lewiston The members were received by Mrs Arthur L. Bennett, president, Mrs Clarence J Durshordwe, program chairman, who was in charge of arrangements, and Mrs Arthur C Hassenfratz, chairman of hospitality Hostesses were Mrs Fred G Carl, Mrs Robert W Lispett, Mrs Lee R Sanborn, and Mrs Elmer A D Clarke

Mrs Harry F Pohlmann, State Auxillary president, was honored by her home Auxiliary at their June meeting, held in Newburgh at the home of Mrs John McKeever, past-president of the Orange County Auxiliary Mrs J Emerson Noll, of Port Jervis, State councilor of the First District, and Mrs Walter A Schmitz, of Middletown, State corresponding secretary, were also guests of honor Schenectady Congratulations from all the

Auxiliaries to Schenectady County Auxiliary on the occeasion of its tenth anniversary! This was celebrated on May 28 at Lake Hill House with all ten Galster, F Leslie Sullivan, William Malla, Albert Greene, E MacDonald Stanton, Charles Rourke, James Blake, Arthur Congdon, William Jameson, and Alfred S Grussner each lighted a candle on the hurthday sole of control of the property of the congdon of the congdo buthday cake as a resume of her presidential year was given The ten-year history of the Auriliary was composed and presented by Mrs Galster and Mrs Sullivan

#### SENATE LEGISLATION TO AID YOUNG SCIENTISTS

On May 21 the Senate passed legislation to set up a \$20,000,000-a-year national science foundation to train promising young scientists and keep the United States abreast of other world powers in pure scientific research in engineering, medicine, mathematical,

physical and biological sciences, and in national de-

It also would set up commissions to study the nature of cancer, heart disease, and the common

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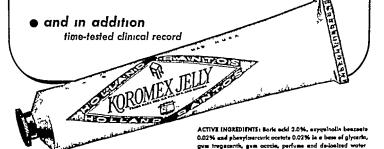
Seventeen doctors seated 25 feet away from an operating table obtained a good view of a delicate operation being performed as though they were within a foot of the surgeon's scalpel

They watched the demonstration surgery through sportsman-type 20-power telescopes mounted on camera tripods in a technic devised by members of the Los Angeles Osteopathic Academy of Ophthalmology and Otolaryngology Further experiments will be made with binoculars and the technic is envisioned as a new method of medical teaching



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#### BOOKS

Books for review should be sent to the Book Review Department at 1313 Bedford Avenue, Brooklyn, N Y Acknowledgement of receipt will be made in these columns and deemed sufficient notification Selection for review will be based on merit and interest to our readers

#### REVIEWED

Peripheral Vascular Diseases By Edgar V Allen, M.D., Nelson W. Barker, M.D., Edgar A Hines, Jr., M.D., with associates in the Mayo Clinic and Mayo Foundation Octavo of 871 pages illustrated Philadelphia, W. B. Saunders Company, 1948. Cloth, \$10 1946

This large, detailed, and comprehensive survey covers all the major aspects of diseases of the peripheral circulation It is written by a group of observers from the Mayo Clinic who have contributed

much to this field

The reader will find it necessary to stop frequently in order to evaluate many of the expressions of personal opinion by the authors They feel the "readers would not want to be left in a maze of controversy" Yet, many of their opinions are frequently open to question For example, they regard oscillometry as the least valuable of all methods of investigating the peripheral circulation and find that palpation of the vessels yields as much information. Such a statement is at complete variance with the studied experience of all the other authors of monographs on this subject great value in arteriography and venography and devote 30 pages to this subject—a method of investigation which at best is difficult, cumbersome, and not adaptable to routine work in this field authors admit that venography does not always provide satisfactory visualization of veins A W Allen and his group failed to obtain satisfactory visualization of venous thrombosis in one third of their case

Aside from these minor criticisms, the book is one of the best and most complete on the subject. It is recommended to both the physician and surgeon, for the diseases of the peripheral circulation comprise such an integral part of medicine and surgery

WILLIAM S COLLENS

Music in Medicine By Sidney Licht, MD Octavo of 132 pages Boston, New England Conservatory of Music, 1946 Cloth, \$3 00

This most interesting volume offers the gist of a series of lectures to the students of the New England Conservatory of Music The author, a practicing physician and a musician, has selected his material with skill, and concisely, yet quite completely, sets

forth the place of music in medical therapy

The chapters covering the history of music in medicine, and the philosophy and psychology of music will prove of exceptional interest to the layman as well as to the physician Detailed discussion must be omitted here, however, in view of misconceptions held even by the cognoscenti, this reviewer cannot resist the temptation to quote from an article by Gilman which the author has used in considering the interpretation of music "It is obvious that the power of music to depict objects, situations, or ideas is extremely indefinite. No matter how specific a pictorial or dramatic program the composer may have in mind to present through his music, the listener will never get that program from the music ıtself "

Music is of greatest value in institutions for the chronically ill, such as those for psychiatric or tubercular patients, but it can play an important role in the operating room, as occupational therapy, or in the convalescence from any illness In the general hospitals of the Army, music therapy was very important, its use might well be considerably extended in our civilian institutions. The author outlines a plan of organization for such a project

This book is heartily recommended to all who

share in the treatment of the sick

MAYER E Ross

Early Ambulation and Related Procedures in Surgical Management By Daniel J Leithauser, M D Octavo of 232 pages, illustrated field, Illinois, Charles C Thomas, 1946 Spring-Cloth,

The author gives an enthusiastic description of the benefit derived from early ambulation following major surgery

The patient is persuaded to be out of bed within twenty-four hours after major surgery Care is taken to protect the abdominal wound with firm strapping after secure closure with wire sutures

The wounds in these patients are found to heal more rapidly and convalescence is shortened Respiratory conditions are rare and bodily strength more rapidly re-established. The maintenance of fluid balance and prevention of dehydration are more readily attained

STANLEY B THOMAS

Rehabilitation Its Principles and Practice By John Eisele Davis, Sc D Revised edition Octavo of 264 pages, illustrated New York, A S Barnes and Company, 1946 Cloth, \$3 00

This revised edition brings the material up to date, and in a wider perspective than that presented in the first edition of 1943 Herein, rehabilitation therapists, especially those obligated to serve the mentally and emotionally sick in varying degrees,

will find a valuable and practical treatise

The author reveals marked and unusual versatility as an integrator of pertinent fields in rehabilitation This approach should be of essential value to the occupational and recreational therapist, educator of the handicapped, psychologist, social worker, and psychiatrist A handy volume, which should be at arm's reach of the busy rehabilitator

FREDERICK L PATRY

[Continued on page 1622]



### WHENEVER NUTRIENT INTAKE MUST BE AUGMENTED

The occasion frequently arises when the intake of all essential nutrients must be increased as in general under nutrition following recovery from in fectious diseases and surgical trauma and during periods of anorexia when food consumption is curtailed

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and easy digestibility impose no added gastrointestinal burden on the patient. This nutritious food drink supplies all the nutrients considered essential for a dietary supplement biologically adequate protein readily utilized carbohydrate easily emulsified fat B-complex and other vitamins including ascorbic acid and essential minerals. The recommended three glassfuls daily virtually assures normal nutrient intake when taken in conjunction with even a fair or average diet.

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IRON	12.0 mg.	COPPER	0.50 mg.

\*Based on average reported values for milk

[Continued from page 1620]

For Practitioners and Diseases of the Skin By George Clinton Andrews, M D on Octavo of 937 pages, illustrated Third edition Octavo of 937 pages, illustrated Philadelphia, W B Saunders Company, 1946 Cloth, \$10

The third edition of this book brings the subject matter up to date, with penicillin, streptomycin, and the sulfa drugs having their appropriate places

The book is profusely illustrated with pictures that amply supplement the text, and supply a visible recording of the subject under discussion

Numerous additions and deletions have been made, in order to streamline the subject matter, and to bring it into harmony with current knowledge

The book can be used to advantage by the student, practitioner, and the specialist

George F Price

The Extremities By Daniel P Quiring, Ph D, Beatrice A Boyle, Erna L Boroush, and Bernardine Lufkin Octavo of 117 pages, illustrated delphia, Lea & Febiger, 1945 Cloth, \$2 75

For teaching purposes and for a rapid superficial review of gross anatomy of the musculoskeletal part of the extremities, the book has some value Also, for those interested in locating approvimate motor points of the extremity muscles, the diagrams may be useful in a practical way

WALTER SCHMITT

The Second Forty Years By Edward J Steightz, M D Octavo of 317 pages, illustrated phia, J B Lippincott, 1946 Cloth, \$2 95

This volume is a worthy addition to the many that have appeared recently. The long neglected subject of "Old Age" has finally come of "Age." This work differs from others in that it is written primarily for the layman, not that the doctor also would not profit by its perusal. It is difficult in a brief review to cite its many interesting features and to present some differing views Suffice it to say that it contains so much good advice and so much common sense that it does greatly help one in "Growing old gracefully, happily, and usefully," and that is an

S R BLATTEIS

Problems in Abnormal Behavour By Nathaniel Thornton Duodecimo of 244 pages Philadelphia, Blakiston Company, 1946 Cloth, \$2 00

This book deals with the vagaries and irregularities of human behavior It is intelligently written and in language that general practitioners and laymen can fully understand

Mr Thornton's experience in teaching abnormal psychology has enabled him to present the subject in a clear and interesting manner

The author discusses his subjects frankly and in the light of the more recent advances in psychology. psychoanalysis, and psychiatry

WILLIAM E McCullough

Muscle Festing Techniques of Manual Programmation By Lucille Paniels, MA, Marie Axamina-MI, and Cathering Worthingham and Williams, of 189 pages, illust ated Phi MA Quarto Faunders Company, 156 Paperadelphia, WB This paper-covered illustrated, loose-leaf manual

is of value to Departments of Physical Medicine and The authors compare methods of mual muscles tests If they could Orthopedics grading of manual muscles tests widely publicize to the medical profession methods as used by the Committee on After Effects, National Foundation Infantile Paralysis, they would have attained much

JOHN J HAUFF

Intracramal Complications of Ear, Nose and Throat Infections By Hans Brunner, M D Octavo of 444 pages, illustrated Chicago, Year Book Publishers, 1946 Cloth, \$6 75

The profession will appreciate a condensed yet complete volume on intracranial complications of ear, nose, and throat infections

Few authors are better qualified as the result of personal investigation based on so much clinical and laboratory data

Brunner describes in detail various avenues of infection of intracranial structures originating in and about the ear, and paranasal sinuses and the logical methods of localizing and combating such lesions

The book is adequately illustrated and practically arranged The author and publishers are to be com plimented

H MEYERSBURG

By Lt Col. A Concise Presentation Henry J John, M C Octavo of 300 pages, illus St Louis, C V Mosby Company, 1946 trated Cloth, \$3.25

The principles involved in the recognition and management of diabetes mellitus and its complications are presented by a clinician of national stand-It is written for the general practitioner and is based on the author's personal experience in handling more than 5,000 diabetics. An almost excessive number of case histories are presented. The best number of case histories are presented chapter that summarizes the author's rich experience is entitled "Some 'Do's' and 'Don'ts'

The author has presented a point of view based on his interpretation of clinical and experimental This is difficult to do in diabetes without appearing to oversimplify some problems Rather broad conclusions and interpretations are drawn from some individual case reports in the opinion of this reviewer

DUNCAN W CLARK

The Personality of the Preschool Child The Child's Search for His Self By Werner Wolff Octavo of 341 pages, illustrated New York, Grune & Stratton, 1946 Cloth, \$5 00

The author states that one can form a fair esti mate of the personality of a preschool child by considering together the summary of the behavior of that child as given by the trained staff of a nursery school, the graphic expressions of the child (drawappropriate interpreted by an expert in this field, and the child's ill guage interpretations of his own draw-This type of approach he calls psychology in depth and includes an excellent survey of personality studies to date

KENNETH G JENNINGS

[Continued on page 1624]



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[Continued from page 1622]

An Atlas of the Commoner Skin Diseases By Henry C G Semon, D M Third Edition Octavo of 343 pages, illustrated Baltimore, Williams & Wilkins Company, 1946 Cloth, \$12

This is a most excellent addition to the armainentarium of any medical man. In its 341 large-sized pages, over one hundred and thirty excellent, modern plates in full color are certain to offer its possessor much assistance in the diagnosis of all of the commoner diseases of the skin, but an added section now includes many of the uncommoner diseases. Unlike most atlases, the author's text is very enlightening and instructive, especially on treatment

NATHAN THOMAS BEERS

Clinical Methods of Neuro-Ophthalmologic Examination. By Alfred Kestenbaum, M D Octavo of 384 pages, illustrated New York, Grune & Stratton, 1946 Cloth, \$6 75

It seems to the reviewer that the book was written more for the neurologist who would like to know about ophthalmologic conditions. The tests enumerated are numerous, many without much merit, so that the average ophthalmologist would be confused. A serious defect is the lack of sufficient simple illustrations, while much included properly belongs to books on ophthalmology, such as the tests for phorias and tropias. The chapter on nystagmus is excellent although repetitious. The book is not without merit and would serve as an excellent reference for those especially interested in the subject

DANIEL KRAVITZ

Gastroenterology in General Practice By Louis Pelner, M D With the collaboration of Louis A Held, M D, and contributions from Alexander Lewitan, M D, Samuel Waldman, M D, and Siegfried W Westing, M D Large octavo of 285 pages, illustrated Springfield, Illinois, Charles C Thomas, 1946 Cloth, \$750

This book was written with the aim to include most of the gastrointestinal diseases met with by the practitioner. It was intended as a practical presentation rather than a complete reference work. It has met this purpose adequately, to serve as an introduction to the specialty of gastroenterology.

In order to present this subject from a clinical, laboratory, radiographic, and psychosomatic aspect in a short text, there resulted, of necessity, some brevity and limitation of details. This book should prove valuable to those physicians desiring an introduction to this specialty.

M J MATZNER

Medical Research A Symposium Edited by Austin Smith, M D Octavo of 169 pages, illustrated Philadelphia, J B Lippincott, 1946 Cloth, \$5 00

This is a modest volume of 159 reading pages, contributed by nine men, whose standing is of such eminence that whatever each one writes is well worth

serious attention

We are inclined to accept the results of medical research without much thought of the untiring effort, the heartaches, the many disappointments that enter into the final achievement

All phases of this question are agreeably and entertainingly presented here. The chapter on the Fundamentals of Medical Research by Dr. Torald Sollmann is a delightful experience. And the one by Dr. Walter C. Alvarez on Chinical Research with a Note Book should stimulate the clinician toward a more liberal use of "eyes, ears, and a notebook."

The chapter on Photography in Medical Research by Drs Milton G Bohrod and H Lou Gibson is a revelation to the uninformed Herein are contained a number of beautiful illustrations And in like manner all the other contributors adequately fulfill their mission

All in all the reader on completion of this small volume will have his respect and regard for Medical

Research greatly deepened

S R BLATTEIS

Treponematosis By Ellis H Hudson, MD Edited by Henry A Christian, MD Octavo of 119 pages New York, Oxford University Press, 1946 Cloth, \$2 50 (Reprinted from Oxford Loose-Leaf Medicine)

Treponematosis denotes and includes a series of diseases with protean manifestations which present different clinical patterns under different climatic and sociologic conditions, and all have a common factor in the etiology, in that they are all caused by the treponeme

Most physicians have a very hazy conception of yaws, and nonvenereal syphilis is a medical curiosity Syphilis and sex are invariably linked and they do not know that this is only part of the story. The fact is that the same disease under other names runs riot through many parts of the world as a childhood disease, without reference to sex

This book will be very instructive to physicians who are interested in the treatment of diseases

caused by the treponeme

PHILIP GOLDFADER

Harvey Cushing A Biography By John F Fulton, M D Octavo of 754 pages, illustrated Springfield, Illinois, Charles C Thomas, 1946 Cloth, \$500

This book deals with the life story of a great medical pioneer I' roughout, it indicates Cushing's many contributions to experimental and clinical surgery, particularly in the field of neurologic surgery, his stimulating association with younger men, his unusual literary gifts, and his human personality The author, Dr John F Fulton, a friend and associate of Cushing, has had access to an unusually rich source of materials, which Cushing systematically preserved throughout his life, and which the author has treated with objectivity and great understand-The result is an account of a brilliant medical figure, a stimulating teacher, scientist, surgeon and, above all, a "good doctor". The medical student, the person interested in a thrilling period of American can medicine, and the general reader will find the biography of Harvey Cushing absorbing and stimulating

EMIL GOETSCH

The Diagnosis and Treatment of Bronchial Asthma By Leslie N Gay, M D Octavo of 334 pages, illustrated Baltimore, Williams & Wilkins Company, 1946 Cloth, \$500

This text endeavors to meet the needs of the medical student, the internist, or medical diagnostician, and the general practitioner of medicine. It is apparently not intended for detailed study by the allergist, though certain aspects of bronchial asthmas, such as pathology, pollen surveys, psychosomatic considerations, and the local treatment of lymphoid tissue in the nasopharnynx by radium are presented fairly extensively.

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#### IF YOU HAVEN'T SEEN THIS ELSEWHERE

Are Doctors Competent to Deal With Health?

MESSRS Wagner, Murray, and Dingell have frequently been severely criticized because their legislative proposals for compulsory health insurance have been written without benefit of medical advice or counsel In fact, we believe it has been rather well established that this much-discussed national health program bill, like most other health insurance acts proposed in the various state legislatures, was drafted exclusively by nonmedical people

Until recently the quaint proposition that medical men might be presumed to have a special competence in dealing with health or medical legislation never appeared to arouse much interest outside medical

circles

On March 5, however, this theory received unexpected support from a rather surprising source when Mr Van A. Bittner, organizing director of the CIO, told the Labor Committee of the House of Representatives that "men who know nothing about a proposition shouldn't deal with it" Mr Bittner declared that the members of this Committee were not "going to give labor a fair break" because "there are no labor men on this committee"

"I doubt if the twenty-five men on this committee who know very little about labor relations could write a good labor bill," said Mr Bittner, and, he observed, "Twenty-five blacksmiths would be a poor crowd to deal with medical and health problems Twenty-five doctors might do a good job

Apparently it all depends upon whose bed is being made up, for we don't recall that the representatives of organized labor expressed any misgiving as to the competence of the Senators serving on the Committee on Education and Labor of the 79th Congress to write satisfactory health and medical legislation (Satisfactory, that is, to organized labor )

On the other hand, the idea that professional men are qualified to administer professional affairs apparently does not appeal to the Honorable Watson B Miller, Federal Security Administrator, who is quoted in the New York Herald Tribine as having told the Expenditures Committee of the US Senate on March 17 that it would be "dangerous" to require the Under-Secretary of Health (provided for in the Taft-Fulbright Bill) to be a licensed medical doctor and the Under-Secretaries for Education and Labor to be "experienced and trained professionals" in their respective fields

The bill would set up a Secretary of Health, Education, and Security in the President's Cabinet with Under-Secretaries for each of these fields who would be people of recognized standing in their respective realms Mr Miller, it seems, does not like this idea He questioned whether the three professional Under-Secretaries could "allay the specialized bureaucratic interests and pressures which the very nature of their appointments would almost certainly call forth" He expressed doubt that they "could be in a position to contribute to the balanced program the people have a right to expect Professional limitations (sic) for such top-level officers are foreign to our history," he declared — New York Medicine April  $\delta$ ,

#### COMMUNITY PROGRAM TO FIGHT HEART DISEASES TO BE EXPANDED

Plans to expand the number of local groups of the American Heart Associations in the United States were announced in June at the Twenty-Third Annual meeting of the Association

Describing the number of local Heart Associations as madequate to meet the nation-wide need for research, service, and education, Dr Howard F West pointed to the tremendous increase of public interest

in diseases of the heart and circulation "This interest," he said, "was demonstrated during National Heart Week in February, and it is now being shown by the continuous requests from communities throughout the nation for assistance

in organizing local Heart Associations in their areas "
The reorganization of the American Heart Association to provide for the admission of laymen on all of the Association's governing and executive bodies, was cited by Dr David D Rutstein, medical director, as an important step in securing the full cooperation of scientific and lay groups in developing addi-

tional local Heart Associations

Officers for the 1947-1948 term were elected at the annual meeting of the association Dr Arlie R. Barnes, chairman of the Board of Governors of the Mayo Clinic, Rochester, Minnesota, was elected president President-elect is Dr Tinsley R Harrison, professor of medicine, Southwestern Medical College, Dallas, Tevas Other officers elected were vice-president, Dr Carl J Wiggers, Cleveland, traesurer Samuel Hard Wiggers, the Ages treasurer, Samuel Herrell, president of the Acme-Evans Company, Indianapolis, and secretary, Dr Harry E Ungerleider, of New York City A contribution of \$17,629 received from the New

York area in response to the Association's drive for funds to support research and service in the cardiovascular diseases in the metropolitan area was announced by Dr Edwin P Maynard, Jr, president of

the New York Heart Association

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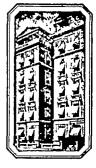
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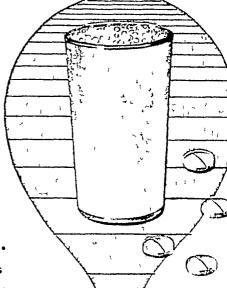
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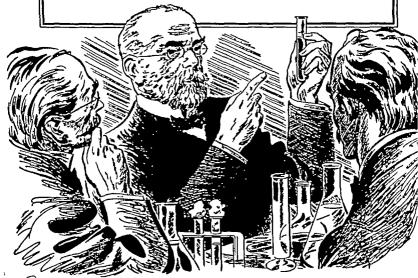
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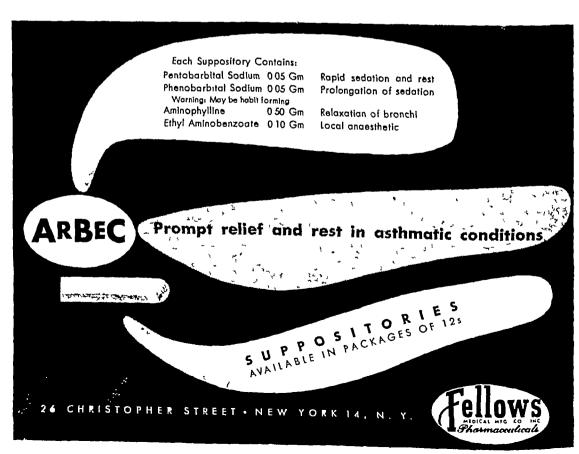
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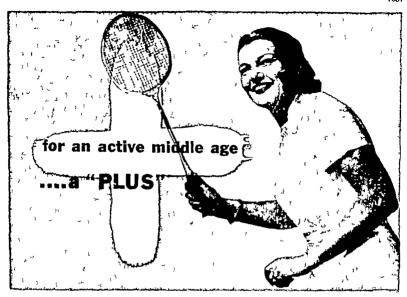
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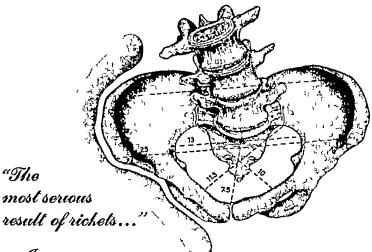


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- 2 M. M. Ellot and E. A. Park, Brennemann's Practice of Pediatrics W F Prior Co., Inc., 36:66 1946
- 3 J B. De Lee and J. P Greenhill Obstetrics, W B Sanders, 1943

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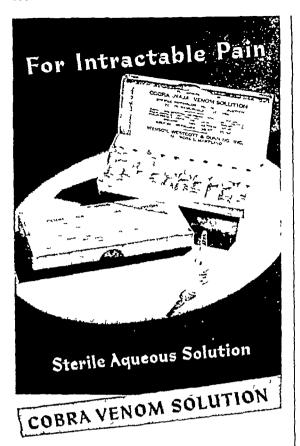
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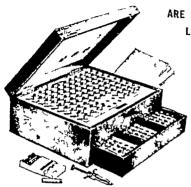
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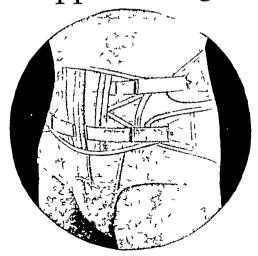


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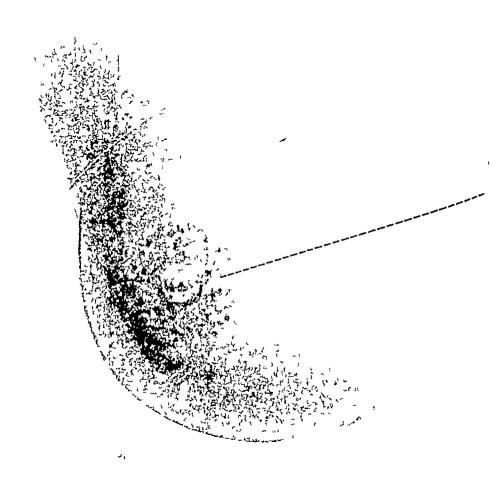
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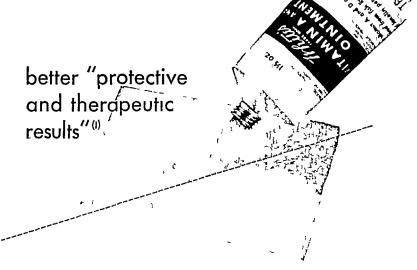


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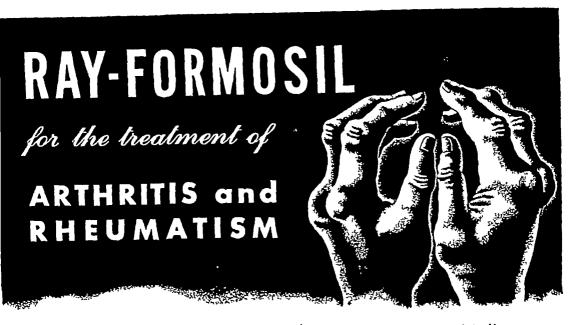
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 Brougher J C.: Prevention and Treatment of Postpartum Fissured Nipples with Local Applications of Vitamin A and D Ointment, West. J Surg., Obst. & Gynec., 52:520, 1944

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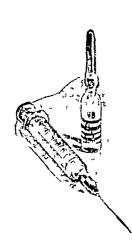
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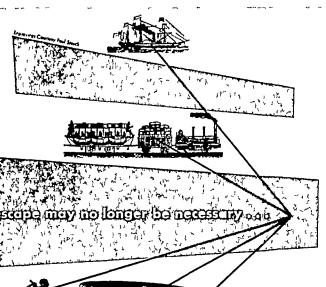
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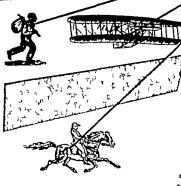
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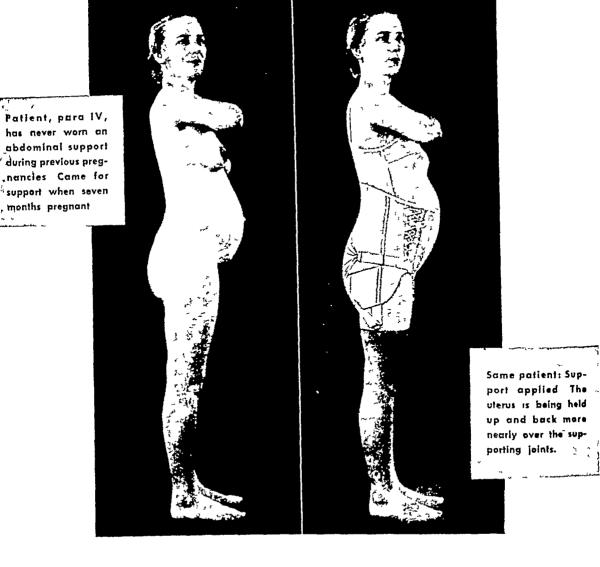




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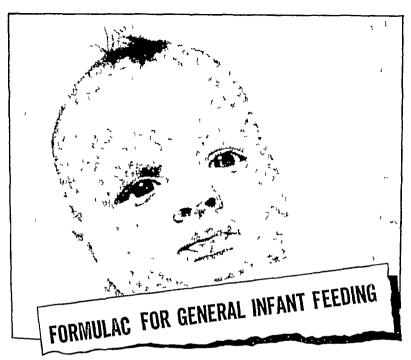
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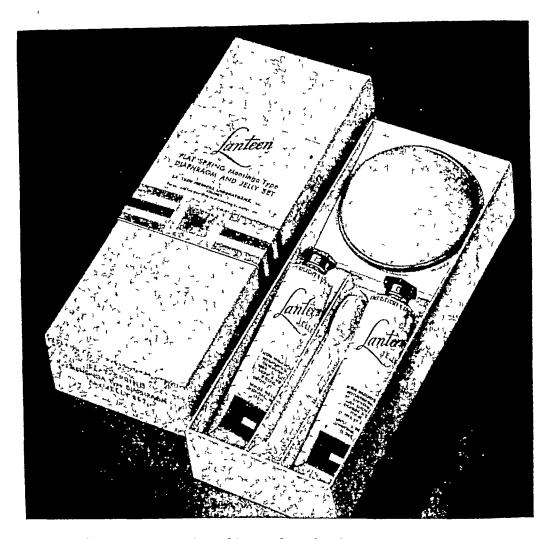
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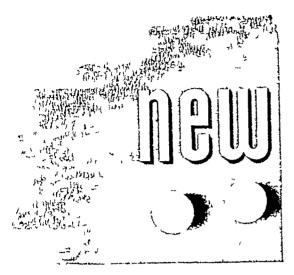
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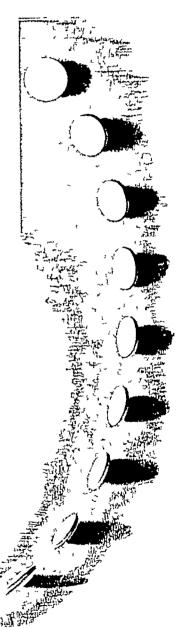


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The President of the American College of Surgeons, Dr Irvin Abell, has sent Sir Alfred Webb-Johnson a cheque bringing the total contribution of that College to the restoration of the English College to over £10,000, and a brochure recording the names and addresses of the Fellows of the American College who have contributed to this memorable gift is being prepared. It may be recalled that the Great Mace of the American College was given by the consulting surgeons of the British Army in memory of mutual work and good-fellowship in the war of 1914–1918.

In the course of his letter to Sir Alfred Webb-Johnson, Dr Abell writes "From its founding in 1913 the American College of Surgeons has been benefited by its cordial relations with the Royal College of Surgeons of England, after which it was in many respects patterned Sir Rickman Godlees, a nephew of Lord Lister, was president of the English College in 1913, and he personally represented his organization at the inaugural convocation of the American College of Surgeons, presented an official message of greeting, good wishes, and hope, and was received into Honorary Fellowship in the newborn College Since that eventful occasion many mutual interests have strengthened the bonds between the two organizations and their individual members."

two organizations and their individual members."
The American College will make a presentation of a desk and lectern for the lecture theatre of the English College during the Congress of the International Society of Surgery to be held in London in September of this year—British Medical Journal, May 31, 1947



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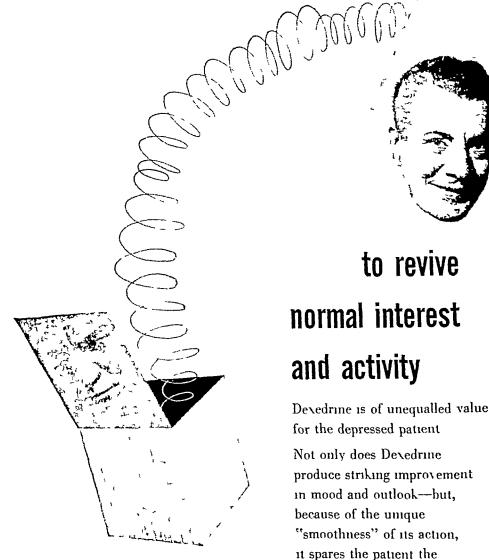
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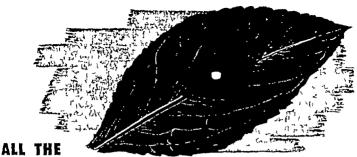
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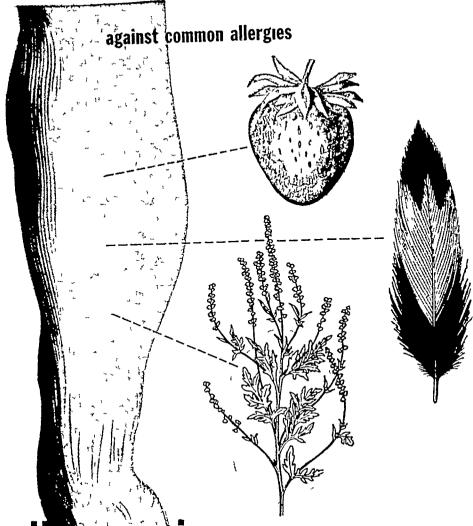
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## NEW YORK STATE JOURNAL OF MEDICINE

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**VOLUME 47** 

AUGUST 1 1947

NUMBER 15

#### Editorials

#### The Pure Investigator

We quote from a book that deserves to be more widely known than it is. "It seemed to Plulip that the people who spent their time in helping the poorer classes erred because they sought to remedy things which would harass them if they themselves had to endure them, without thinking that they did not in the least disturb those who were used to them. The poor did not want large airy rooms, they suffered from cold, for their food was not nourishing and their circulation bad, space gave them a feeling of chillness, and they wanted to burn as little coal as need be, there was no hardship for soveral to sleep in one room, they preferred it, they were never alone for a moment, from the time they were born to the time they died, and loneliness oppressed them, they enjoyed the promiscuity in which they dwelt, and the constant noise in which they dwelt pressed upon their ears unnoticed. They did not feel the need of taking a bath constantly, and Philip often heard them speak with indignation of the necessity to do so with which they were faced on entering the hospital, it was both an affront and a discomfort. They wanted chiefly to be let alone. "1

For many years we have wished that those lines might be read daily to everyone entering upon a life of Social Service. What a preventive of busybodyism and moral snobbery they might be! They were written out of Mr Maugham's experience as a medical student doing outpatient obstetric work. They recalled an experience of ours under similar circumstances when we visited bluetering invective upon a woman who, one-day postpartum, was up cooking dinner for her family

"Young man, when you've had as many babies as I have I'll listen to you telling me what to do."

Early convalescence was not fashionable in those days

Salvation can never be inflicted on the poor by prying uplifters. The desire for it must come from within and the roots of the desire possibly may be stimulated and nurtured by education.

Thinking along those same lines—that a wide acquaintance with humanity in all its

<sup>&</sup>lt;sup>1</sup> Maugham, W Somerest: Of Human Bondage, New York, George H. Doran Company 1915, pp. 598-99 <sup>2</sup> New York Times, Magazine Section, April 20, 1947 page

phases was an essential part of a doctor's training—our eye tripped over the following sentence, which occurs in an article on racial tensions in the city of Detroit and the measures being taken to combat them "They include volunteer investigators and reporters upon social conditions teachers, social workers, ministers, students, bartenders, union leaders, shop foremen, and merchants, representing different geographic areas, racial, and religious groups"<sup>2</sup>

Why does not the group include doctors? The doctor should be the ideal investigator. He can go anywhere and be welcomed anywhere because, wherever he goes, he is minding his own business. He is not easily shocked by what he sees, because no matter what he encounters he often has

seen worse elsewhere He invades his territory because he is invited into it to relieve pre-existing suffering, not because he wants to poke his nose into a nasty situation so that he can write a thesis for his Ph D on the disgusting conditions he uproots. He is not swayed by preconceived theories as to what social conditions ought to be. He is summoned to face a fact and to do the best he can about it.

We wish Detroit every success in its effort to ward off trouble, but we think the city might get further if it included in its investigative staff a few hard-headed, unsentimental, practical doctors, who only encountered the unpleasant facts they found because they were invited to see them while minding their own business

#### Bars or Freedom

Somewhere in Belgium there is a happy village. We cannot at the moment recall its name, and if we could, we would not print it because we do not wish its happiness to be disturbed by swarms of curious visitors from the outside world.

A majority of its inhabitants are insane Coming from everywhere in Belgium they are committed to the town instead of being confined in institutions. We don't know what the Belgian criterion of insanity may be. We do know that in this country fai too many of our potentially useful fellow critizens are locked up behind bars, kept at the public expense, when in the opinion of their families, their friends (?), and their communities, their conduct deviates no more than slightly from the normal

With the exception of the indisputably violent, who are as dangerous to their fellow men as might be a frightened tiger evicted from his cage into the unfamiliar environment of the ordinary world, most of the insane are not so bad. What the exact dividing line is between them and us is difficult to establish

Are there not hundreds of us who wish we could withdraw from our environment? Are there not thousands who wish they could escape the perils of love, the struggle for existence, the "slings and arrows of outra-

geous fortune" An insane person is simply one who has more or less successfully done so He has shifted his burdens from his own shoulders to those of the State Smart felloy

The kindly citizens of our Belgian town recognize that fact If a man arrives among them who is happy in the belief that he is Napoleon, they welcome him and allow him to establish his Empire over the village pigs How they treat a woman who thinks she is Cleopatra we don't know But we don't believe she suffers from lack of attention

We are daily bombarded in the public prints by horrendous statistics of the rising percentages of the insane. Perhaps we are getting a little too fussy about who is insane and who isn't

Some years ago a Southern lady, somewhat over fifty, came to our office to ask if we couldn't help her get a former pupil of hers out of the Hudson River State Hospital We were astonished The request seemed a little out of our line Then she mentioned the lady's name, and we at once remembered her as one of the most beautiful memories of our college days Three marriages, it seemed, had somewhat upset her, and one of her families had had her committed

"What made them think that she was crazy?" we asked

"The last time they let her out of the Hospital she went to Washington, took a room in a hotel, bought a bottle of whiskey and cut her telephone wire"

"We've often wished we had guts to do that very thing That doesn't make us

think that she was crazy"

Our visitor looked surprised, but an unexpected gleam of sympathy suffused her eye Such a statement from a damnyankeel

"Well, if that is your point of view perhaps you would help me to persuade them to let her come down to live with me It's an old Southern city and there isn't a family of any decent age and respectability in it that hasn't an aunt, uncle, cousin, or some aged relative, no matter how distant, living with them, who isn't a little bit queer

"They aren't regarded as insone They are simply members of the first families who for one reason or another are considered as amiably eccentric—practically the equivalent of a

patent of respectability"

Our efforts for liberation and custodial care were unsuccessful, but the incident gave us to think About that town in Belgium Most normal people in normal

towns don't get on so well The divorce rate rises constantly

Suppose you and your wife lived in a community in which 75 per cent of the community were admittedly insane? Your husband is not everything that you might wish. Neither is your wife.

But as you survey the community you have constant reassurance that there are lots of people in it crazier than you are. Such an

assurance is always heartening

What is a normal person? Does anybody know? It might not be a bad thing if more of our citizens, labelled as slightly deranged, were distributed among our self-considered normal ones. The constant comparison afforded might sharpen our perceptions in regard to the gradations of mentality. What beautiful charts would result.

Under such a system of constant admixture of the normal and the abnormal, of constant observation by the community at large of the various manifestations of in sanity, such persons as Hitler and Mussolim might have been nipped in the bud Who knows? And how much happier they and many others would be now if they had been

#### Our Waning Intelligence

The British Medical Journal¹ comments editorially on what it terms the "distant prospect of a 'galloping plunge to intellectual bankruptcy'" It seems that the Eugenics Society has published, in a booklet by Sir Cyril Burt, experimental data which "strongly suggests the possibility that, if present population trends continue

(England) faces a progressive decline in the level of our national intelligence."

More intelligent parents in every social class in Great Britain apparently tend to have smaller families. Such a trend in the more numerous working class seems to the British Medical Journal "to be the most ominous portent of all". Methods of evaluation of intelligence and prognostication in population statistics are notoriously difficult. But the subject is serious enough to demand large-scale studies, intensively undertaken by a team "drawn from psycholo-

gists and psychiatrists, sociologists and statisticians." Objective assessment of the facts will need the combined endeavor of mon trained in all the social sciences.

Under the title "Breeding Out Intelligence," the Lancet last year commented upon the 1946 Galton Lecture to the Eugenics Society by Professor Thomson

Prof Godfrey Thomson made a disquieting statement on the trend of national intelligence Having been particularly interested in the selection of children for prolonged school and university courses, he is fearful of the end-result of this lengthy training and for delay or failure in marriage or procreation that it entails 'The educational system of the country' he said, 'note as a sieve to aift out the more intelligent and destroy their posterity It is a selection which ensures that their like shall not endure'

<sup>1</sup> Feb 1 1947 p. 185 1 The Lancet, London No 6418, Aug. 10, 1946, p. 204-

Perennially the question arises as to whether or not the human race is breeding out intelligence. At the moment, three publications lie at hand. The Lancet, London, of August 10, 1946, Human Fertility, Vol. II, No. 2, June, 1946, and The Survival of the Unfittest, Birthright, Inc., Princeton, New Jersey. All three publications above cited exude gloom. The Lancet says, in part

In a survey of the results of intelligence tests in a group of nearly 3.000 school children, Thompson and Sutherland found that there was a negative correlation (r = 0.25) between intelligence quotient and size of family means that, in 60% of the families studied, smallness of family was associated with mental ability above the average There is a consistent trend from the 66% above-average intellects in only children to the 39% above-average intelligence-test results in families of over That this was not wholly due to difseven ferences in home environment was shown by subsequent demonstration of a similar association in the children of miners on the same social level

This earlier work was strikingly confirmed by a very comprehensive study, by Fraser Roberts and his associates, of intelligence among an entire age-group of the children of Bath They, too, showed this definite negative association between the children's intelligence quotient and the size of the family to which they belonged

Human Fertility (loc cit) publishes an article by Clarence J Gamble, M D, "The Deficit in the Birthrate of College Graduates," raising the spector of the Dodo bird for the male and female college graduates in measured phrases and words of solemn portent

The need of large numbers of a highly educated personnel in modern society is obvious and the evidence of a present deficit in those with the hereditary qualities needed to absorb such education is inescapable

To all of which Marion S Olden in Birthright, Inc., (loc cit supra) adds The Survival of the Unfittest, in which Henry Pratt Fairchild is quoted on population trends

The population of the world up to a century

and a half ago was much more nearly stationary than we are inclined to suppose suddenly something happened during the Nineteenth Century humanity added much more to its total volume than it had been able to pile up during the previous million years, and in 150 years it nearly trebled the number These are the most amazing figures in the whole gallery of statistical pictures essential significance is actually incomprehensible We are blind to it only because the habituation of our own individual life-time causes us to regard as "natural" or "normal" that which is really absolutely unique in human experience

The article includes extensive analyses of statistics to show what sort of people are producing those who will be responsible for the future of this country It is shown that college graduates and high-school graduates had underreplaced themselves by 45 per cent and 21 per cent, respectively, while those with only one to four years of grade school had overreplaced themselves by 95 per cent Also, it was found that the lowest economic third of our families have overreplaced by 76 per cent, while the highest economic third has underreplaced by 19 per This difference has increased among women of 30 to 35 years

This assortment of statistical gloom from various recent sources can be intensified at will by referring back to Robert Thomas Malthus who, in 1798, published his Essay on the Principles of Population, which set out to prove that increase is dependent on warmth and food, and population checks upon the lack of these, or by such positive factors as disease, epidemics, wars, and Follow this by a light dose of Herbert Spencer who, around 1848, speculated that all organic development is a change from homogeneity to heterogeneity Then dip into Oswald Spengler for a review of his belief in the life cycle of each civilization as expounded in his Decline of the West

But don't stop there, gentlemen, for a little contrast in style and content, leap to 1930 with Señor Ortega y Gasset His Revolt of the Masses (W W Norton Co) will bring to your attention the European mass mind and its workings, together with the inwardness thereof and its historical background Ortega y Gasset with no implication of humor says

<sup>1</sup> Harper's Monthly Magazine May 1988

"The Mass Man is he whose life lacks any purpose, and simply goes drifting along And it is this type of man who Hence, at times he decides in our time leaves the impression of a very primitive man suddenly risen in the midst of a very old civili zation In the schools it has been impossible to do more than instruct the masses in the technic of modern life, it has been found im possible to educate them they have been hurnedly inoculated with the pride and power of modern instruments, but not with their spint.

And, was it not Dr Larnest Albert Hooton,

who, in 1940, advised all and sundry how to tell your friends from apes, in a volume (Princeton University Press) entitled Why Men Behave Like Apes and Vice Versal

This brings us nearly up to date with practically no light shed on the question of whether or not we are breeding out intelligence. Perhaps this in itself is a slight indication that the situation is not yet hopeless. With the British Medical Journal, we agree that more study and better methods of study are needed, perhaps, also, some revision of our concept of intelligence. We add this thought for the record

#### Current Editorial Comment

The Physician and the Narcotic Laws The New York State Pharmaceutical Association has issued a handy reference booklet in which are presented the legal requirements pertaining to the prescription of narcotics. This booklet has been mailed to the physicians of the State and the information should prove of great value. The Pharmaceutical Association deserves the appreciation of the doctor for bringing these important matters to his attention.

Excepta Medica. Under this title a new series of abstract journals has been launched in which the world's medical literature will be abstracted in English The publication is an international undertaking of which the central administration has been set up in Amsterdam under the direction of an editorial board of three well known Dutch physicians, and supplemented by a list of specialists representing all parts of the world

Fifteen separate sections of the new venture will be devoted to the various sections of medicine, surgery, and allied fields. These are to be issued at monthly intervals in English and publication is promised to begin late in 1947. The American agents are Williams and Wilkins Company, of Baltimore, from whom further detailed information may be secured.

Ship's Surgeons The New York Times for Friday, June 20, 1947, carries the following headline on page 3 "Ship Surgeons to Choose Union Bargaining Agent" "Surgeons," says the special despatch, "will vote in a collective bargaining election for the first time in history under an order of the National Labor Relations Board to-day." The board ruled that "surgeons employed by the Grace Line, Inc, constitute an appropriate bargaining unit." It ordered an election "to determine whether or not the surgeons desire to be represented by the American Merchant Marine Staff Officers' Association, affiliated with the A. F. L."

This will be interesting to observe The election is ordered Why? Apparently, in all the honorable history of ships' surgeons a union affiliation has not been found necessary

It is not observed or stated that the ships' surgeons desired an election for this purpose Such an election is ordered by the National Labor Relations Board "within ninety days," if we read the despatch correctly Why? And if the ships' surgeons do not choose such an affiliation, what is the alternative?

We seem to recollect an action of the Borough Council of Willesden in England in the recent past which ordered the professional staff of its hospital to join a trade union—or else

After all, it's a small world, isn't it? Apparently full of Boards of Something or Other Boards pushing people around for one or another reason best known to themselves—Ho, hum! Likely, one of these days somebody will push right back—hard

### The President's Page

A WORLD MEDICAL ASSOCIATION is now in the process of organization, the objects of which are as follows

1 To promote closer ties among national medical organizations and among the doctors of the world by personal contact with all other means available

2 To maintain the honor and protect the interests of the medical profession

To study and report on the professional problems which confront the medical profession in the different countries

4 To organize an exchange of information on matters of interest to the medical profession

To establish relations with and to present the views of the medical profession to the World Health Organization, UNESCO, and other appropriate bodies

To assist all peoples of the world to attain the highest possible degree of health

At the present time the national medical associations of the following countries are participating Austria, Australia, Belgium, Canada, Chile, Czechoslovakia, Denmark, Egypt, Eire, France, Great Britain, Hungary, Netherlands, Norway, Palestine, Portugal, Spain, Sweden, Switzerland, and the United States

The final meeting of the Organizing Committee was held in London April 14 and 15, 1947. The Organizing Committee consists of representatives from Belgium, Canada, Czechoslovakia, Egypt, France, Great Britain, Spain, Sweden, Switzerland, and the United States. The first plenary session of the new Association will be held in Paris, September 16 to 20. The Association expects to publish a journal as a medium of exchange of information.

The Association will be organized into a General Assembly to which each participating association will be entitled to send two delegates, and a Council which will consist of the officers and nine elective members. The Council will be the governing body. The Chairman of the Organizing Committee is Dr. T. C. Routley, of Canada. There is a joint Secretariat, consisting of the secretaries of the British and French Medical Associations.

The Organizing Committee at its recent meeting completed a draft of the constitution and bylaws to be submitted to the General Assembly for ratification. It also completed a draft of a questionnaire to be sent to every national medical association. The questionnaire covers a survey of the following subjects in each country professional organizations, present tendencies in medical practice, organization of medical service, conditions of general practice, conditions of consultant and specialist practice, medical services in industry, medical education and medical research, and status of medical practitioner

This new organization has great potentialities. It will afford a mode of reapproachment among the doctors of the world. With the present chaotic state of international affairs, perhaps a beginning of amicable relations can be started by the doctors. They should have no difficulty in getting together as they have one common aim, namely, "to assist all people of the world to attain the highest possible level of health."

Dr Elmer L Henderson, of Louisville, Kentucky, and I attended the meeting of the Organizing Committee in London How close we are to Europe, geographically, was brought home to us by our flight over and back Sixteen hours from New York to London and twenty hours on the return trip

While there we were privileged to inspect the work at two of the largest hospitals in London The editor of the British Medical Journal, Dr Hugh Clegg, entertained us at dinner on our last evening, and at that time we had an opportunity to discuss the New British National Health Act with the chief medical officer of the British Health Ministry and the chief medical officer of the London Hospital Council

Dr Elmer L Henderson and I will attend the plenary session in September as delegates, Dr Roscoe L Sensenich, president-elect of the American Medical Association, Dr Ernest E Irons, Secretary of the Board of Trustees, and Dr James E Paullin, Past-president, will attend as observers

Louis H Bauer, M D. President

### Scientific Articles

#### THE PRACTICAL APPLICATIONS OF ENDOCRINES IN GYNECOLOGY

GEORGE P HECKEL, M D Rochester, New York

In ANY discussion of endocrine therapy it is helpful to have a theoretical argument, for although the important consideration is whether a hormone does or does not work, it is much easier to indicate what to give and when to give it if one proceeds from an hypothesis. Therefore, I shall represent practical endocrine therapy in gynecology as replacement therapy, much as the treatment of diabetes with insulin is replacement therapy. To do this I must review briefly the events associated with the menstrual cycle

The purpose of ovarian function is the production of ova and the preparation of the genital tract for their reception. Ovulation results from stimulation of the primordial follicles of the ovary by genadotrophic hormone of the pituitary Preparation of the uterus for receiving the ovum is brought about by the estrogen produced by the growing follicles in the early part of the cycle and by progesterone from the corpus luteum in the latter part of the cycle. If the ovum is fertilized, progesterone continues to be needed for the protection of the early pregnancy Menstruation occurs if the egg is not fertilized and the corpus luteum does not continue to function

I shall not discuss the gonadotrophic preparations available for treatment for it has never been proved that any of them stimulates the hypofunctioning ovary in which we are interested and some of them, the chorionic, cause degenerative changes in the ovary

The ovarian hormones on the other hand, the estrogens and progestins, induce the same changes in the genital tract which occur normally and as will be seen, there are indications that they may in some way favorably influence the bypophysis

The most obvious deficiency to treat with replacement of hormones is the ovarian failure at the climacteric. It is usually necessary only to give estrogen to relieve the unpleasant symptoms occurring from ovarian insufficiency. At the memopause one should try to relieve the symptoms with as small an amount as possible for it

Presented at the 141st Annual Meeting of the Médical Society of the State of N w York, Buffalo Teaching Day May 6, 1947

is easy to cause bleeding by giving estrogen In younger women with ovarian failure it might be desirable to produce menstruation What can be accomplished with estrogen and progestin in amenorrhea is illustrated in the following case

The patient, H S aged 25 had never had a nor mal menstrual period. Endometrial blopsy yielded nothing but a few opithelial cells even after hielding had been induced a few times by estrogen alone When the patient was given 0.08 mg of ething! estradiol (Esting)\*) duly for two weeks and then progestin 30 mg of Pranone daily for ten days menstruation occurred from apparently normal premonstrual endometrium

Complete replacement therapy of this type is practical, but not useful when it becomes clear, as in this case that nothing beyond periodic bleeding is being accomplished and that the underlying disorder remains unaltered. There are conditions of less complete ovarian failure, how ever, where replacement therapy is indicated to treat abnormal bleeding and where permanent benefit seems to be obtained One of these is metropathia hemorrhagica called aperiodomenorrhen by some because there is complete menstrual irregulanty There are long periods of amenorrhea alternating with periods of prolonged and often profuse bleeding associated with failure of ovulation, persistent follicles in the ovaries, and hyperplasia of the endometrium.

Anovulatory cycles may occur nomally once in a while but there is no upset in the menstrual rhythm because although no corpus luteum is formed, the follicles do not persist. In aperiodomenorrhea the follicles do persist and their continued production of estrogen causes overgrowth of the andometrium. When bleeding does occur it continues because the endometrium is not thrown off completely. Curettage will stop the bouts of bleeding, but one heatnates to recommend it in teen-aged women in whom the condition is frequently seen and I shall show that replacement of progesterone is just as effective and may oven be curative.

Bleeding can be stopped just as effectively with crystalline progesterone in oil 10 mg a day

for five days, or by anhydrohydroxy progesterone (Pranone\*), by mouth, 60 mg daily for five days, as by curettage Bleeding frequently increases for a few days before it stops. Some investigators have reported that the addition of 25 mg of testosterone propionate each day prevents this to some extent

Another patient, A. F, showed what may be accomplished by giving progestin when the patient is not bleeding in an attempt to produce normal men-After giving progestin only to prevent bouts of bleeding when they occurred over a period of seven years, it was used to produce menstruation. since the patient had married in 1944 and wanted to become pregnant Thirty mg of Pranone were given daily from June 22 to July 1, 1945 She bled normally from July 1 to July 9, the first normal flow since 1939 It was planned to repeat this treatment at monthly intervals for five or six months, but it failed to cause bleeding in August and September because she had become pregnant She delivered a normal baby two hundred and seventy-nine days after the artificially produced menstrual period. Similar cases have been ob-The stimulation of a normal served by others cycle by progesterone suggests a beneficial effect on the hypophysis as well as on the endometrium

There are cases which demonstrate that estrogen, as would be expected, is not very beneficial, and that 50 mg of progesterone in one injection may be sufficient to produce bleeding. This hormone is now available in 10-cc vials of oil containing 25 mg per cc.

There are less severe dyscrasias which also may be considered deficiencies according to our hypothesis. Two of these are menorrhagia, excessive flowing at the usual time, and dysmenorrhea. Both with some justification may be considered deficiencies of the corpus luteum. The best argument for this in the case of menorrhagia is the fact that the addition of progestin before the menses is beneficial. As little as 10 mg of Pranone daily for the ten days preceding menstruation may reduce the bleeding to normal.

The argument in the case of dysmenorrhea is a little more involved It is a fact that severe menstrual pains occur only in ovulatory cycles If there is no corpus luteum, there is little or no pain when bleeding occurs, and hence dysmenorrhea may be relieved by preventing the formation of a corpus luteum The most reliable method I know of to relieve dysmenorrhea in any one cycle is the giving of large doses of estrogen, 10,000 rat units of estradiol benzoate, twice weekly during the first half of the cycle, beginning before the fifth day after the onset of menstruation other estrogen of equal potency may be used This can be repeated every other month if need It cannot be done every month, for ovulation cannot be suppressed indefinitely This may be

a useful treatment when a woman wants to do something special when her menses is due, or when it is desirable to give a patient relief occasionally from very severe pain

Progestin given before menstruation may relieve the pain. This is replacement of deficiency of corpus luteum function according to our hypothesis. A deficient corpus luteum is worse than none at all in dysmenorrhea. As little as 10 mg of Pranone each day, beginning a week before the menstruation is expected, may be sufficient. Testosterone, a closely related compound chemically, may do the same. No masculinizing effects need be feared from 30 mg of methyl testosterone daily for the last ten days of the cycle. Ten mg a day, one tablet, may be enough.

Estrogen given before menstruation will relieve dysmenorrhea completely if the patient The dose of 05 to 06 mg of takes enough Estinyl daily (10 to 12 tablets), necessary during a week to ten days before menstruction, causes nausea in a large proportion of patients, and daily injections of 20,000 rat units of estradiol benzoate are impractical This amount of estrogen may postpone menstruation a little and it may prolong bleeding This is unorthodox treatment Estrogen is not supposed to be beneficial in the phase of the corpus luteum I think, in line with the stated hypothesis, that it works through the corpus luteum by maintaining and bolstering it

At this point it will be well to indicate the relative potency of various estrogens Willard Allen standardized them for women, in whom we are most interested Estradiol benzoate is three times as potent as estrone This means that 10,000 rat units of estradiol benzoate are equivalent to 50,000 international units of any preparation standardized with estrone and labeled in international units

The last thing I want to discuss is thyroid, the least expensive hormone of all. There are those who say that it should not be used if hypothyroidism cannot be demonstrated. If this dictum is followed, opportunities for relieving very simply many of the milder menstrual upsets will be missed. A small daily dose of thyroid will do no serious harm and it may do some good. The administration of half a grain of thyroid hormone daily may be followed after a month by a normal menstrual rhythm.

You have noticed that the doses of hormones with the exception of thyroid are relatively large and expensive Smaller amounts are not likely to be effective, however, and prices of the hormones gradually come down as the potencies increase I predict that in a few years we will accomplish more in gynecology by using still larger doses of the ovarian hormones

<sup>•</sup> Eatinyl and Pranone are oral preparations supplied by Schering Corporation, Bloomfield, New Jersey

### FIBROSITIS (MUSCULAR RHEUMATISM) INCLUDING DUPUYTREN S CONTRACTURE A NEW METHOD OF TREATMENT

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PRESENT-day practice finds the surgeon busily occupied converting colons into semi colons, the physician occupied in extending the therapeutic uses of the antibiotics, and all of us crusing most people having "theumatic pains," as suffering from hallucinations of pain. The response initiated by the mentioning of the term fibrositis is most varied. However, the usual response is to raise one's cyclrow or to stimulate the nith cramal nerve to protrude the tongue in such a manner that there is an exterior bulge in the side of the face.

There are three schools of thought regarding the diagnosis of primary fibrositis The "liberal school" calls any recurrent ache or pain in soft tissue structure fibrositis Corroborated evidence is the finding of a "bump" which is gleefully referred to as a nodule. The extreme of this liberality was recently reached when Mylechreest1 labeled hermation of fat through a tear in the fascia of the back as fibrositis The interesting newly-discovered cause of one type of backache was confused by such a diagnosis The hermated mass became a nodule and the tear in the fascia became the ache or pain. The "nihilutic school" states that there is no such thing as primary fibrositis The "conservative school" states that there is such a clinical condition as primary fibrositis but that substantiating objective evidence is required Objective evidence and post tive laboratory findings will be described in this article.

The term fibrositis was first coined by Gowers? in 1904. It means inflammation of fibrous tiesue Many rheumatologists use the term as synony mous to any ache or pain of muscle, tendon, liga ment, fascia, periosteum, joint capsule, and nerve sheath Fibrositis associated with some systemic disease is secondary fibrositis. Primary fibroaltis is diagnosed when any of the aforementioned structures are inflamed and there is no associated systemic disease A more fitting defi nition would seem to be "primary fibrositis is a rheumatoid disorder characterized as a metabolic disturbance affecting mesenchymal tissue ' The clinical course pathology, absence of in creased aedimentation rate, normal white blood count, absence of fever, and the response of the

creatinum to tocopherol therapy all point to a metabolic rather than an infectious basis

#### Incidence of Primary Fibrositis

The reported incidence of primary fibrositivaries considerably, depending on whether the writer is on the east shore or west shore of the Atlantic Ocean English writers have reported fibrositis as frequently as 70 per cent of all rheumatic cases seen

TABLE 1.-INCIDENCE OF FIREGETTS

Copeman Hutchinson Savage Schmidt	1940 1942 194 194 1942	70% of rheumatic cases 69% of rheumatic cases 52% of rheumatic cases 55% in a study of miners.	Army hospital Army hospital

American rheumatologats diagnose fibrositiless frequently About 93 000 American soldiers developed rheumatic diseases during the first World War The incidence of primary fibrositis in this group was 5 4 per cent It was the third most common disabling rheumatic disease An analysis of the first 1,000 rheumatic cases seen during World War II at the Army and Navy General Hospital showed the incidence of fibrositis to be 13 4 per cent

TABLE 2.—Incidence of Various Types of Resumation Diseases Seen at Army and Naty Hospital

DISEASES SEEN AT ARMY AND NAVY HOSPITAL			
Rheomatoid arthritis (including rheomatic spondy litis) "Paychogenic rheomatism" Ostocarthritis	33 1% 20% 13 6%		
Fibrositis Rheumatic favor	13 45		
Conorrheel arthritis Cout	1 0%		
Sciatica, ruptured disk, rare joint diseases, ste. Unclassified diseases of joints and related structures	11 17		

The stimulus to diagnose correctly primary fibrositis is initiated when excellent clinicians find it to be a common rheumatic disorder

Fibrositis usually first appears in the latter part of the fourth decade of life and the peak incidence appears in the fifth decade. It is equally common in both sexes Patients may have primary fibrositis on and off for many years and still have the physical appearance of good health Also there is no muscle atrophy present. The disease is practically always chronic and is characterized by remissions and exacerbations. The exacerbation usually comes on as an acute attack and lasts for weeks rather than days. The pain may vary in severity and may be localized or generalized.

Presented at the 141st Annual Meeting of the Medical Sociaty of the State of New York Buffalo, Teaching Day May 6, 1947

tender nodule or may involve one muscle or a group of muscles. The localized muscle areas are not only tender but are usually indurated and are under spasm. The condition is usually associated with generalized staffness. Drafts and cold damp weather aggravate or initiate an attack. Warm weather or the application of local heat bring relief. A slight degree of exercise usually limbers the patient, and an excessive amount of exercise stiffens them again.

Temporary deformities, such as scoliosis of the back or traction of the head to one side, may result owing to marked spasm of muscle structures involved. A careful physical examination may reveal an associated Dupuytren's contracture in the palm of the hand or fibrositis nodules which are firm, subcutaneous tender nodules. These nodules should be differentiated from lipomas which are usually quite soft and often are much larger than fibrositic nodules. The sessile soft discolored nodules of neurofibromatosis usually offer no difficulty in differential diagnosis. Biopsy of the nodules offers conclusive evidence

#### General Laboratory Findings

The white blood count, differential count, and sedimentation rate are normal in primary fibrosi-An increased sedimentation rate in the presence of a diagnosis of primary fibrositis usually means that the diagnosis is incorrect and that one should be on his guard for an early rheumatoid arthritis A most interesting finding is the presence of creatinuria in primary fibrositis books usually state that a normal male adult excretes no creatine in his urine, children during puberty and pregnant women excrete an appreciable quantity Steinberg has previously reported creatine values up to 136 mg per twentyfour hours in normal male adults. Creatinuria of 150 mg or more for a twenty-four hour period has always been found in primary fibrositis by The usual creatine excretion in a twenty-four hour period in primary fibrositis is in the neighborhood of 300 to 400 mg Some of these patients excrete even larger quantities The creatinum usually responds to tocopherol therapy The usual response is one of gradual reduction of creatine excretion while under such therapy

Occasionally, however, the opposite occurs There is an increased urmary creatine excretion under tocopherol therapy. Also, at times the creatine excretion diminishes during the first few weeks of treatment and then begins to rise and continues to do this unless the dose of tocopherol is increased. These various responses are found in experimental animals in whom nutritional muscular dystrophy has been produced with a vitamin E deficient diet. The giving of tocopherols to these animals with nutritional

muscular dystrophy usually results in a decrease of creatine excretion in the urine. However, at times the creatine excretion rises and at times it drops initially, only to rise unless the dose is increased. The biochemical factors concerned with these variations are unknown at the present time.

Vitamin E can be determined accurately in a blood plasma by the method of Quaife and Harris 5 They found the blood plasma levels of tocopherols to be between 0 9 and 1 6 mg per 100 cc, with an average of 12 mg in a series of healthy human individuals Steinberg4 has found the vitamin E blood level in primary fibrositis to be normal in 27 cases vitamin E level was found to be low in 3 cases Two of these individuals had notoriously inadequate diets One case had cirrhosis of the liver, this has been found to interfere with the absorption of vitamin E from the gastrointestinal tract The lowest vitamin E blood level of these 3 cases was 0.75 mg per cent The lowest vitamin E blood level found in a controlled series of study in which the patient had marked portal cirrhosis of the hver was 0 36 mg per cent In a study of 50 cases of secondary fibrositis, the vitamin E blood level was found to be normal

Several conclusions might be determined from these studies (1) The diet of patients suffering from primary fibrositis usually contains normal quantities of vitamin E (2) The absorption of vitamin E from the gastrointestinal tract is normal in primary fibrositis unless interfered with by extreme liver damage (3) Although the vitamin E intake is sufficient and the absorption from the gastrointestinal tract adequate, the ability of the muscle structure to utilize vitamin E is disturbed Corroborating evidence of this difficulty may be obtained by vitamin E utiliza-If normal healthy individuals are tion curves given a single large dose of 1,500 mg of vitamin E and then blood levels of vitamin E determined at two-hour intervals during a twelve-hour period and repeated the following morning, a "peak" curve is obtained However, the blood level in primary fibrositis tends to rise more slowly and then tends to flatten out In other words, a plateau curve is obtained A low vitamin E blood curve is obtained in patients in whom absorption of vitamin E from the gastrointestinal tract is inadequate

A deterrent in the correct diagnosis of primary fibrositis has been paucity of gross or microscopic tissue studies. The writer previously has described the microscopic pathology of biopsied sections of muscles in patients suffering from primary fibrositis. These changes consisted of areas of muscle degeneration with loss of cross striations and disappearance of nuclei. Other sections have shown active fibroblastic activity and also round-cell infiltration. The blood

vitamin E level in these previously reported cases was normal. The creatine excretion was excessive and the creatinuma responded to tocopherol therapy.

A white man aged 50 was seen recently who gave a sixteen year history of aches and pains in various soft tissue structures of the body nation revealed poor muscular tonicity of the entire body, particularly noticeable in the biceps of both arms The initial blood vitamin E level was 0 70 mg. per cent, which is definitely reduced The vitamin A was 210 units per cent and the carotene was 192 gamma per cent. A biopsy of the biceps muscle revealed occasional degeneration of muscle fiber with abnormal arrangement of the nuclei occasional muscle giant cell was noticed areas of lymphocytic infiltrations were present. Similar findings have been described by Goettsch and Pappenheimer in E-deficient guinea pigs and rabbits.7 This patient was placed on 300 mg of mixed natural tocopherols daily. After two weeks of such therapy the blood vitamin E rose to 0 91 mg per cont, vitamin A 216 units per cent and the carotene was 160 gamma per cent. A repeat biops: was done four weeks after the initial biopsy findings were somewhat improved over the previous The muscle fibers were swellen homogencous, and the striations, while present were faint. There was slight peripheration of nuclei No round cell infiltration was noticed There was marked clinical improvement in this patient case 15 of unusual interest in that it represents a patient with muscle disease in whom the original blood vitamin E level was low owing to insufficient intake of the vitamin The clinical response at the end of the four weeks' treatment was very marked The patient was practically free from all aches and pains although the anatomic changes were only alightly improved

Dupuytren's contracture is a form of primary fibrositis. The usual pathologic picture is one of dense fibroblastic tissue which squeezes out the fat and deeper structures of the skin and dips down to surround the flexor tendons of the fingers. Thus, it produces contracture of the flexors of the fingers. The tissue is more cellular and vascular in the earlier stages. There is associated sclero-derma of the skin as evidenced by thickening of the cornified layer thinning and flattening of the stratum mucosum and obliteration of the corium which normally extends deep into the epidermis

#### Differential Diagnosis of Primary Fibrositis

The most difficult problem that arises in the diagnosis of primary fibrositis is its differentiation from psychogenic rheumatism. One of the most practical tests to employ is the "sedative" test. This consists of giving the patient phenobarbital in a doee of 16 mg three times daily. The patient with primary fibrositis is not benefited but the patient with psychogenic rheumatism is re-

heved of his or her symptoms Creatinums is a common finding of primary fibrositis and is absent in psychogenic rheumatism The patient with primary fibrositis is cooperative and objective in his viewpoint whereas the patient with psychogenic rheumatism is tense, anxious, defensive, antagonistic, and subjective in his viewpoint The patient with primary fibrositis is able to localize the joint and muscle symptoms to a definite area or areas. The patient with psychogenic rheumatism "can't quite describe it" He usually places his hand over his entire anatomy rather than localizing to a particular area. The patient with primary fibrositis complains of aching soreness stiffness, fatigue. The patient with psychogenic rheumatism complains of burn ing tightness, weakness, numbress, tingling queer, or tired sensation

The patient with psychogenic rheumatism has "misery" all the time The patient with primary fibrositis usually has a definite pattern of pain He is stiff in the morning on arising, loosens up during the early part of the day, and stiffens as the day goes on Physical exertion aggravates the symptoms of primary fibrositis In other words the stimulus is external. The stimulus in psychogenic rheumatism is internal the or she is in conflict with themselves and with their environment Mental preoccupation gives very little if any relief to patients with primary fibrositis but often relieves the patient with psychogenic rheumatism If the latter individual can occupy himself at playing cards or having one or two high balls, he or she feels fine This is not true with primary fibrositis Heat usually relieves patients with primary fibroaitis and aggravates patients with psychogenic rheumatism. Aspirin relieves primary fibrositis but is usually ineffective with nationts with psychogenic rhoumatism same is true of physical therapy, it produces temporary relief from fibrositis but makes the pa tient with psychogenic rheumatism worse of the most outstanding differential points is that patients with psychogenic rheumatism have bisarre symptoms such as headaches sighing respirations, precordial pain, insomnia nervousness tremor etc

The nodules associated with other diseases and conditions should not cause too much difficulty. It has been stated previously that the so-called lumps of lipoma are usually soft and are not tender. The nodules of neurofibromatosis are soft and discolored. The nodules associated with rheumatoid arthritis are usually quite large and are not as deeply buried in the subcutaneous fusue as these of primary fibrosits. Occasion ally hemangioma may be confused with a fibrosi tie nodule. Also herniation of the fat through the fascia in the back may do likewise. No

creatinuria is present in any of the latter conditions

#### Treatment of Primary Fibrositis

Various methods have been employed for the treatment of primary fibrositis Krusen has advised muscle massage with a circular movement in order to "rub out the nodules" Slocumb has previously used "fibrositic vaccine" Kelly has described a reflex pain originating from the myalgic lesion in primary fibrositis 10, 11 He,10 with Pugh and Christie, 12 has advocated finding trigger points and injecting these with procaine solution with temporary to permanent relief in various cases Removal of foci of infection has been tried

It is difficult to understand how the infectious theory has entered into the treatment of primary fibrositis as the condition definitely is not asso-An increased sedimentaciated with infection tion rate or elevated white blood count usually means some other disease, usually rheumatoid arthritis Also, it is difficult to understand how deep massage, that is, rubbing an area of inflammation, can possibly cure the condition The trigger point injection with procaine solution is intriguing, but at the best it is usually a temporary and not a permanent expedient

The close similarity of the pathologic picture found in primary fibrositis and in that found in nutritional muscular dystrophy stimulated me to try vitamin E in the treatment of primary fibrosi-The results with this treatment were first reported in 1941 The usual average dose has been found to be 300 mg of mixed natural tocopherols, of which 60 per cent is in the form of alpha tocopherol which is given in equally divided doses daily Clinical response is usually obtained in a period of two to four weeks of such treatment Objective evidence of the success of such treatment has been found in Dupuytren's contracture Clinical cure in patients having a history of Dupuytren's contracture up to one year has appeared as early as after four weeks' Marked improvement occurred in a physician who had Dupuytren's contracture for at least thirty years, nine months' treatment was required in order to bring about his improvement, although complete clinical cure was not ob-It was meffective in a patient having tained Dupuytren's contracture associated with portal cirrhosis It has been shown that the blood vitamin E level is low and that large doses of vitamin E are not absorbed in these cases haps, the giving of bile salts along with vitamin E might bring about clinical improvement in such a case

A maintenance dose of 1 mg of mixed natural tocopherols per kilo of body weight has been suggested in order to prevent recurrence of the con-It has been found that patients who stop tocopherol therapy have a recurrence of Dupuytren's contracture or fibrositis in a period of several months after its cessation Some patients require larger maintenance doses, necessitating a total dose of 150 to 300 mg daily in order to prevent recurrence. It is these factors that suggest that the normal metabolism of the muscle for vitamin E is in some way disturbed and that its disturbance is not due entirely to insufficient intake or to a disturbance in absorption from the gastrointestinal tract Recurrence of Dupuytren's contracture after surgery is common suggested that mixed natural tocopherols be given in a dose of 100 mg three times daily preceding or following such surgery in order to prevent recurrence

#### Conclusion

- Primary fibrositis is a metabolic disorder resulting in disturbance of mesenchymal tissue function
- 2 The blood vitamin E level in primary fibrositis is usually normal The only exceptions found to date are a woefully madequate diet or liver disease which prevents absorption of the vitamin E from the gastrointestinal tract
- It is possible that what is called primary fibrositis divides itself into two clinical states An absence of a coenzyme or enzyme factor necessary for muscle or connective tissue to properly utilize vitamin E could explain the situation Changes in these tissues actually may be due to an insufficient amount of vitamin E in the diet
- 4 Creatinuria is a common finding in primary fibrositis
- 5 Dupuytren's contracture is a form of primary fibrositis which is remedied by tocopherol It may be used as a sole method of treatment in early cases of Dupuytren's contracture and may be used associated with surgery in the more chronic cases
- Continued biologic and chemical studies are indicated in the field of muscle metabolism More chemical and pathologic studies will aid in the clearing up of the various states which are now called primary fibrositis

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#### RECENT DEVELOPMENTS IN THE CARE OF PROSTATIC DISORDERS

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UROLOGY, along with other branches of medicine, has achieved rather marked ad vances in therapy and procedures during recent years. We who have practiced for two or three decades marvel at the improvements in the handling of diseases of the prostate, especially the relief of prostatic obstruction.

The subject is too great and time will not allow a complete discussion of all phases of the subject. Much of it will be a review along with the opinion of the author and his associates as to the present status of these developments. For brevity and clarity the subject will be discussed under the following classification

- 1 Urmary Antiseptics in Prostatic Diseases
  - Operative Procedures
    - a. Pre- and postoperative care
    - b Anesthesis
    - c. Operations
    - d Hemostatic agents
- 3 Hormone Therapy

#### Urinary Antiseptics

Sulfonamides, pencillin, and streptomycin have verified the statement made a few years ago that the greatest advance in medicine would be through chemistry and allied sciences Their value in urinary tract infections, including infections associated with prostate pathology cannot be measured Their efficiency is so great that there is a tendency to prescribe them in all types of infections without determining the organism involved or associated obstructions, residual urine stones, or abscess formation. The fact that all organisms are not affected by any one of these drugs, the danger of toxic symptoms and complications, and the question of the organism becoming resistant to the drugs make their indiscriminate use a definite hazard to the patient.

The Sulfonamides—Because of their elimination through the urmary tract, these allow smaller desage, thus adding to their efficiency in such infections. Colon bacillus infections, the most common type found in the urinary tract infections, react to these drugs. They are now in our experience, rarely effective in gonococcus infections. We have found that when one of the drugs is not effective another may give excellent results. Large amounts of fluid and alkalinization will prevent complications in most cases.

Sulfadiazme, sulfathiazole, sulfacetimide and

Presented at the 141st Annual Meeting of the Medical Society of the State of New York, Buffalo, Tesshing Day May 8, 1047 sulfamerazine are the most common types of sulfonamides. We prefer sulfathlasele because of its ready absorption and lessened tendency to form crystals in the urine Sulfamerasine would appear to be less toxic and smaller doses are effective.

Mandelamme —A combination of mandelic acid and methenamine, this is quite efficient in colon bacillus infections, it has replaced simple methenamine long-used by many doctors

Pencillin—This new addition to our list of antiseptics is potent at the present time in gonorheal infections. In nonspecific prostatitis due to staphylococcus and mixed infections it seems to be of benefit, along with local treatment. Its administration has been made easier with the development of oral and the slowly absorbed becever a preparations.

Streptomyen — This preparation is effective in gram-negative bacillary infections as well as those due to gram-positive cocci including the nonhemolytic streptococcus. Although experience is limited, most workers stress the importance of delaying treatment until the species of the bacteria is isolated and its sensitivity to streptomyen tested. Keefer and others also warn of its probable failure in infections associated with stone and obstruction. There is, apparently, a great tendency to permanent drug resistance when small doses are given.

Because of the structure of the prostate gland, we cannot expect deep and walled-off infections to be completely eradicated with drug therapy. We still must rely upon such time-hothored procedures as removal of foci of infection, prostatio massage, urethral dilatation, irrigations, deep instillations, hot rectal irrigations, dlathermy, and endoscopic treatments to effect the control of the infection.

The above-mentioned preparations have also contributed much to the pre- and postoperative care of operative cases. Hinman has stated that, "The dangers of proscrastination grow greater and greater as urinary antiseptics grow better and better" With this in mind we must investigate our cases of infection that do not respond or recur checking the residual urine, prostatic expression, and x raying for stones. With correction of complicating factors not only will our antiseptics be more efficient but renal tissue will be conserved

#### Operative Procedures

Pre- and Postoperatus Care -The preoperative

care of the prostatic patient formed one of the cornerstones in the foundation of urology The attainment of proper renal function before removal of the prostate is about as important now as then—no matter what type of procedure is carried out

To this fundamental procedure have been added the urinary antiseptics, referred to above, and the use of transfusions, not as a lifesaving procedure but for restoring the blood picture to normal so that the patient will better withstand surgery and, most important, possible complications Vitamins, amigens, plus drainage, fluids, blood, and antiseptics usually will place the poorest surgical risk in condition so that he can be relieved safely by modern surgical procedures

Probably the most important development in postoperative care in urology, or other branches of surgery, is the early ambulation of the patient. The great value of this was noted by urologists in the postoperative care of patients subjected to prostatic resection. This procedure made possible the early ambulation of these elderly men and this constituted a major part in affording relief to many who could not be operated on otherwise.

Bed exercise adapted to the individual case is another lesson taught by the late war and probably not used as widely as it should be

Slotkin advocates the use of ascorbic acid, 25-mg doses four times daily, postoperatively, in cases showing evidence of pulmonary complications in this prostatic age group <sup>1</sup> Since using this drug in patients who show moisture in the lungs, rise in temperature, and respiratory rate, he has noted rapid and startling results with reduction of temperature, cough, and expectoration

Prevention of fatal emboli by saphenous ligation in cases presenting phlebitis has been developed recently and is used extensively, especially by the group at the Massachusetts General Hospital

Colby reported in October, 1946, that 1,500 vein ligations had been carried out at that institution to prevent emboli <sup>2</sup> In 1939 and 1940, before ligations were performed, there was a 6 per cent incidence of thrombosis or emboli following prostatic surgery and fatal emboli in nearly 3 per cent. During the years of 1943 and 1944, among the same class of patients treated with early ambulation, there was a 2 per cent incidence of thrombosis or emboli and a 0.9 per cent mortality from emboli. With the use of prophylactic vein interruption or anticoagulants there had been no fatal emboli for the past year.

Colby states that tenderness in either calf muscle in a postoperative patient is sufficient evidence of venous thrombosis or of early pulmonary infarct <sup>3</sup>

Anesthesia - The development of departments

of anesthesia, a rather recent event and still not available in a large number of hospitals, has been one of the most important and valuable factors in the surgical handling of prostatic disease

The judgment of the trained anesthetist, after surveying the patient and considering the surgery contemplated, in prescribing and carrying out the proper anesthetic is of the greatest value in this particular age group. Their recognition and prophylactic care of respiratory complications are dramatic and may mean much to the poor-risk patient.

Spinal anesthesia, although not a recent development, now entails new technics, it seems ideal in prostatic surgery where high abdominal anesthesia is not required and where immediate postoperative local comfort is desired in patients, especially in those with cardiac complications. It is used routinely in our resection work and the anesthetic, with the skill of the Deptarment of Anesthesia, plays a good part in the low mortality achieved.

Pentothal sodium, for short anesthesia or a basal anesthetic, is favored by many operators and anesthetists. Although widely used in offices and hospitals with apparently little regard for possible disaster, most anesthetists consider it a drug requiring great care in administration because of its depressing respiratory effect. The immediate availability of resuscitation equipment, when pentothal sodium is used, also is advocated

Etsten and Himwich recently have described states and signs of pentothal anesthesia upon a physiologic basis <sup>4</sup> These were based upon studies of brain metabolism during pentothal anesthesia

Combined with nitrous oxide, patients can be carried very lightly and in cystoscopy, where later cooperation of the patient is necessary in making pyelograms, it is most useful

Pentothal sodium is very pleasant and patients like it—For short procedures and under proper circumstances, it seems an ideal anesthetic

Caudal anesthesia, using 1 per cent metycaine, is an ideal anesthesic for use in men when complete and time-consuming cystoscopy is necessary Continuous caudal, as used in obstetrics, has been used in prostatic surgery as reported by Davis and Lee <sup>5</sup> It is felt that it would have no advantage over low spinal anesthesia in such work

Operations—Suprapubic Prostatectomy For the removal of the enlarged prostate, in one or two stages, this has been the procedure of choice for most general surgeons and urologists for many years. It has stood the test of time as not too difficult an operation and one giving excellent functional results

However, the long hospital stay, the often slow

closure of the sinus, the occurrence of emboli the inability to deal with malignancy, the associated discomfort, and the high mortality in poor risks were some of the disadvantages noted

Improved urinary antiseptics anesthesia, and general preparation of the patient have reduced the operation to more frequent one-stage affairs, lessening the hospital stay. The closure of the capsule, improved hemostatic bags, and agents which allow earlier removal of the suprapulate tube and more prompt closure of the sinus have led to earlier discharges.

Early ambulation, vein ligation, and other postoperative aids have reduced mortality hospital stay, and discomfort. Series are now reported in which the patient is discharged on the fourteenth to twenty-first day and mortality is reduced to between 5 per cent and 10 per cent.

Millin, of London, reports a new retropuble and retrovesical prostatectomy which he claims has advantages over the intravesical enucleation \*

Suprapuble prostatectomy in one or two stages with the employment of the newer pre- and post-operative care, is still one of our best urologic operations, since it gives more certain results when used by those surgeons not skilled in the other procedure

Permeal Prostatectomy This operation devel oped by Young, with modifications by Loweley and others, although less frequently used, is probably the most surgical of all procedures for blad der neck obstruction

Through a perineal exposure of the gland, suspicious areas can be biopsied and if found to be malignant the radical perineal operation can be carried out. New developments in this operation have to do with the technic whereby the danger of incontinence is lessened and the veruinontanium preserved. Lowsley plicates the membranous urethra with a mattress suture of ribbon-gut to further lessen the frequency of this complication and has developed an operation for incontinence based upon that method

Belt has modified the perineal approach by utilizing a plane of cleavage near the rectum and claims it to result in ease of exposure and less involvement of blood yessels.

Radical Perneal Prostatectomy for Carcinoma of the Prostate Young developed this operation for the oure of carcinoma of the prostate As the name implies it is radical, with removal of half of the trigone internal sphincter, the entire prostate gland including the seminal vesicles, and a part of the membranous urethra.

With this extensive surgery he reported a low mortality and with improved technic complete urnary control in almost every case. The operation requires considerable skill and experience in order to achieve not only good functional results but also complete removal of the carcinoma which is the real reason for such an extensive operation

The indications for the operation as a curative procedure are limited due to the fact that car cinoma of the prostate may be present for a con siderable period of time without symptoms and with early invasion of the perineural routes of the pelvis, the sacrum, the lumbar vertebrae and femur

These make early diagnosis most difficult and again emphasize the great importance of rou tine rectal examinations in men. An early nodule biopsy, and radical perineal prostatectomy may produce a cure so seldom presented at present

Colston, discussing this operation, states that Young performed it upon only 87 patients from 1904 to 1939. He found that in only 5 per cent of cases extension had not taken place and Lowsley reports that in less than 5 per cent of his series metastases had not occurred and cure might be attained

Thompson and Emmett state that postmortem studies by several investigators showed extension beyond the confines of the gland in cases in which the primary lesion was very small

Scott and Parlow have suggested the use of this procedure in late cases after control of the local disease and metastases has been obtained with estrogonic therapy. 10 This combination may provide another indication for the radical operation

The greatest hope of effecting a cure apparently lies in the discovery of an early nodule by routine rectal examination before symptoms, biopsy, and radical perineal prostatectomy. The few cases meeting these conditions should not deter us in our efforts to cure prostatic careinoma surgically as is done in carcinoma involving other organs.

Transurethral Resection of the Prostate or Transurethral Prostatectomy This procedure has changed the entire picture of the surgical care of prostatic obstruction. From its early indication in fibrous bars, contracture of the vesical neck, and small median and lateral lobe obstruction, it has developed to the point where, in many clinics it is the only procedure used in relieving obstruction in beingn conditions. A review of the prostatic surgery in any large urologic service reveals an increasing percentage of resections.

Some modifications of the original Stern McCarthy resectoscope have been made by Nesbit and others but the wider use of the instrument has been due to increased skill in its use. With sufficient skill it is possible to remove the prostate as completely as in the usual suprapulor and permeal operations. Without adequate skill the removal of large glands should not be attempted for the poor results and serious complications are not fair to the patient or the operation

It is still a question in the minds of many as to whether the handling of all types of benign obstruction by any one procedure is proper or possible. It is our opinion that except for the very early case of carcinoma, where the lesion is apparently limited to the gland, the transurethral operation, in skilled hands, is the procedure of choice. With all types of removal, except in the radical operation, recurrences will develop in a small percentage of cases. Carcinoma developing following this operation appears to be no more frequent than in suprapubic and permeal prostatectomies.

In obstruction due to carcinoma of the prostate, with extension and metastases, it gives relief in the simplest manner Combined with immediate or later orchiectomy and estrogenic therapy, we are giving the patient, with little risk or discomfort and a short hospital stay, the utmost in palliative treatment

Prostatic calculi, so frequently a complicating factor in prostatic infections and making eradication of infection most difficult, can be removed satisfactorily by the transurethral approach.

Dr William A Milner in the Section on Urology\* will report his results in transurethral prostatectomy in patients eighty years of age and over. One hundred and eighty-one patients were relieved of obstruction during the past five years, with eleven deaths, a mortality rate of 6 1 per cent as compared with a rate of about 2 per cent for the entire series over a five-year period. Ten deaths occurred during two years. The causes of death were cardiac, five, pneumonia, five, unknown, one

No longer is age a factor in the contraindications for this operation. Rarely is physical condition such that the patient cannot undergo this procedure. The comfort afforded these elderly men for their remaining few years makes the operation a most humane and satisfactory procedure

Hemostatic Agents in Prostatic Surgery Hemostatic catheters, such as developed by Foley and Hendrickson have made possible, to some extent, the excellent results attained in transurethral surgery. In suprapulic prostatectomy they also have a place and allow a shorter period of suprapulic drainage

The development of nonremovable substances for the control of hemorrage has been of great value in prostatic surgery

Thrombin (topical) in solution and upon gauze to be removed was one of the early products. Fibrin foam and gelatin sponge are used in prostatic operations. Quinby has had satisfactory experience with these latter preparations. Fish has reported upon the use of ovidized cellulose, an absorbable hemostatic gauze.

There is apparently little tissue reaction and it was efficient in the control of hemorrhage following prostatectomy. Elimination of the pain associated with the removal of gauze and the occasional case of secondary hemorrhage following such removal are other advantages in the use of oxidized cellulose.

#### Hormone Therapy

Hormonal Treatment of Benign Prostatic Hypertrophy—The relationship of endocrines and prostatic hyperplasia has for many years attracted the attention of investigators. Its development with advancing years would suggest that it has some possible association with testicular secretion. However, experiments have shown no definite evidence of such relationship

There have been reports of clinical improvement of symptoms associated with prostatism which were effected by the administration of male hormones, but there has been no definite demonstration of a change in the size of the gland Many patients feel better physically and mentally and there may be improvement in the urinary stream. Hamilton, Heslin, and Gilbert attribute this to improved muscular tone. 13

The effect of female hormone upon prostatic hyperplasia has been studied by Kahle in 1940,14 and Hamilton et al in 1936,13 among others Kahle concluded that the hypertrophied glands were reduced in size with some alleviation of symptoms after the administration of stilbestrol our studies an attempt was made to confirm Lower's contention that 49 out of 76 patients were benefited by inhibiting the pituitary with injections of testicular substance Since the administration of female sex hormone results in definite inhibition of the pituitary, this preparation There were no striking improvements which might be expected if Lower's contention One patient did show relief of some symptoms but the size of the gland remained the same

Carroll, in a recent review of the literature on the effects of endocrines upon hyperplasia, states that, "It would appear that true hyperplasia of the prostate gland has not been produced by endocrine therapy or accelerated by endocrine therapy" He found no proof that endocrines had any effect upon the normal, adult prostate gland

Lowsley and Kirwin, in their textbook, state that the subject is still in an experimental stage and further laboratory and clinical studies must accumulate to determine the true place such therapy has in benign prostatic disease <sup>16</sup>

Hormone Treatment in Carcinoma of the Prostate Gland—Unlike the questionable position of endocrine therapy in benign hyperplasia of the gland,

<sup>\*</sup>To be published in a later issue of the JOURNAL.

effects of such therapy in carcinoms has produced the newest, the most dramatic, and most publeased development in the treatment of prostatic disease

As a palliative measure it has brought about miraculous results in the relief of pain and although the hopes of it being a cure have van ished, the relief afforded those affilieted with the disease has earned for itself a high place in the humane achievements of science.

Huggins and his coworkers are responsible for the clinical application of research on the effect of androgens and estrogens upon acid phosphatase in proetatic carcinoma.<sup>17</sup>

Kutscher and Wolbergs are mentioned by Lowslev and Kirwin as having observed high concentration of serum and phosphatase manifesting its optimum activity between a pH of 45 and 6 <sup>18</sup>. This ensyme activity apparently is elaborated by the prostatic epithelium and increases from a small amount in infancy and childhood to high levels in the adult. It also is found in the blood stream and quantitatively determined by several methods. The so-called King Armstrong method is a popular one and the normal is given as 40 units per 100 cc. of blood.

The Gutmans found a large amount of this scrum add phosphatase in carenomatous tissue of the prostate and in the metastases and blood scrum. This finding is of value in the differential diagnous between bony metastases of carcinoma and Paget's disease, as well as being an aidd in the early diagnosis of prostatic carcinoma.

Elevated blood levels of serum and phosphatase occur only in carcinoma of the prostate with metastases, but such metastases may be observed without elevated levels. Sarum alkaline phosphatase levels may indicate the activity associated with the healing of bone lesions due to carcinoma of the prostate.

Huggins in his original work presented evidence of the concept that carcinoms of the prostate is composed of epithelial cells of a mature type which, in common with all other types of adult prostatic epithelium is responsive to depression of the levels of androgenic hormones. This sensitivity of prostatic carcinoma to androgen levels was shown by the change in serum acid phosphatase levels by the use of androgens. Injections of male hormone increased acid serum phosphatase, and female hormone, by decreasing amount of male hormone, caused a lowering of acid phosphatase.

Huggins felt that custration, to secure a quicker, more complete removal of the undrogens, was a more satisfactory method than the use of formale hormone. In May, 1941, he selected several cases of advanced carcinoma of the prostate with metastases and noted after castration increased appetite and gain in weight, an elevation in hemo-

globin, decreased pain, decrease in size of prostate gland, and stabilisation or regression of bony metastases

Munger at the same time reported his experiences with irradiation of the testicles in the treatment of carcinoma of the prostate <sup>11</sup> His object was also the elimination of male hormone from the testes

Six years have proved the correctness of Huggins' contribution, and hormone therapy is standard treatment for prostatic carcinoma and its metastages.

The method of control of male hormone varies in different clinics, as follows (1) estrogens alone and later orchiectomy, (2) orchiectomy and later estrogens, (3) the two methods combined

Experience would indicate that in either manner of reducing the androgens they cannot be controlled indefinitely at the present time. When one method fails it is unusual for the other method to be effective, although it is our feeling that orchiectomy is more apt to give further relief when estrogens fail than the use of estrogens after orchiectomy has failed. It was felt that the adrenal gland might be a source of supply of the androgens influencing these late results of hormone therapy.

Huggins reported the results of bilateral adrenalectomy in prostatic cases where recurrence after orchiectomy had taken place." Two patients died soon after the operation because of insuffi ment substitute therapy, one patient lived 116 days and showed a reduction in the excretion of 17 ketosteroids in the urine, but the growth of the prostatic carcinoma was not entirely inhibited although retarded. He concluded that it was not a practical method of treating prostatic carcinoma He also believed that the excellent results after orchiectomy depend upon a type of carcinoma which is androgen-dependent, and upon testicles which are producing a large amount of androgen. In some there is an extragonadal production of androgen when estrogen therapy will be necessary In the poor results after orchiectomy he believes we are dealing with a type of carcinoma classed as androgen-independent.

The time of use of orchiectomy in prostatic carcinoma may be most important. In a series of 112 cases, in which complete follow-up was possible, we were greatly pleased in 78 cases with the results of orchiectomy performed at the time diagnosis was made and resection performed Huggins was, until recently at least, doing routine orchiectomy in all cases

I believe that most clinics including our own now do orchiectomy only when metastases are present with pain and elevation of and serum phosphatase. Whether the therapy has some prophylactic action delaying metastases or

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whether its later use may give a longer regression of the symptoms has not been determined

Hormone therapy apparently will not cure carcinoma of the prostate, but it does provide a means of affording great relief and prolonging the lives of our patients, which is, after all, one of our most important duties in the practice of medicine

75 WILLETT STREET

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#### NEW STATE COMMISSIONER OF HEALTH APPOINTED

Gov Thomas E Dewey on June 28 appointed Assistant Surgeon General Herman E Hilleboe, who has been associate chief of the Bureau of State Services of the United States Public Health Service, as Commissioner of the Department of Health of the State of New York Dr Hilleboe succeeds Dr Edward S Godfrey, Jr, who retired recently

Dr Hilleboe's appointment became effective Shortly after assuming his new office he was scheduled to leave for a three-week tour of Europe, to study health and tuberculosis problems on that continent and attend three international health meetings

Dr Hilleboe was born in West Hope, North Dakota, January 8, 1906, and received his elementaryschool and high-school training in Minnesota He received the degrees of Bachelor of Science and Bachelor of Medicine at the University of Minnesota in 1929 He received the degree of Doctor of Medicine from the University of Minnesota Medical School in 1931

He had graduate training in Pediatrics at the University of Minnesota Hospitals at Minneapolis and in public health at the Johns Hopkins School of Hygiene and Public Health, from which he received the degree of Master of Public Health ın 1935

After graduation from medical school, Dr Hilleboe engaged in rural general practice in Swanville, Minnesota Since 1935 he has spent full time in public health work, specializing in tuberculosis con-

In June, 1939, he was appointed as a senior assistant surgeon in the regular corps of the Public Early in 1939, he made special Health Service studies for the Public Health Service in tuberuclosis control in the Scandinavian countries, England

Germany and France

Huggins C

Dr Hilleboe served with the Minnesota Division of Social Welfare in St Paul, Minnesota, as chief of the Medical Unit from 1939 to 1942, on loan from the Public Health Service Since 1942 he has been in charge of tuberculosis control activities in the Public Health Service in Washington, DC On July 1, 1944, he was appointed chief of the Tuberculosis Control Division of the Public Health Service with the rank of medical director On November 1, 1946, he was appointed associate chief of the Bureau of State Services of the US Public Health Service, with the rank of assistant surgeon general

Dr Hilleboe is a member of the Board of Directors of the National Tuberculosis Association, member of the Council of the American Trudeau Society, and member of the Board of Regents of the American College of Chest Physicians He also is professorial lecturer in Tuberculosis at the George Washington College of Chest Physicians University Medical School, Washington, DC, and adjunct professor of medicine, Georgetown University

Dr Hilleboe was appointed by the National Tu berculosis Association on March 10, 1947, as a representative on the Council of the International Union Against Tuberculosis On May 31, 1947, he was appointed as the American member of the Expert Committee on Tuberculosis Against Tuberculosis mittee on Tuberculosis of the World Health Organization, Interim.

Dr Hilleboe has over 60 publications in the medical and public health literature published from 1931 to 1947 He is coauthor with Dr Russell H Morgan, professor of radiology at Johns Hopkins Medical School, of the book, "Mass Radiography of the Chest," published in 1945

#### THERAPEUTIC APPLICATIONS OF CURARE AND THEIR PHYSIO LOGIC IMPLICATIONS\*

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(From the Neurological Institute)

HE clinical use of curare is based on its ability L to create a transient block to neuromuscular transmission at the myoneural function eral properties have been recognized for more than one hundred years As early as 1833 John Morgan<sup>1</sup> of London demonstrated its usefulness in ameliorating the convulsive phenomena of both strychnine and tetanus in animals However since the source of supply was so unpredictable and the active agent poorly understood, the drug has remained until recently an experimental rather than a therapeutic tool In recent years important steps have been taken in isolating and identifying a crystalline derivative of the crude alkaloid with predictable properties and to acity

Tubocurarine is now known to be a quaternary ammonium salt. These salts as a group have the property of paralyzing conduction at the myoneural junction Tubocurarine, uniquely, in certain concentrations has an almost pure myoneural junction effect. This property is of great clinical significance, and because of its physiologic and therapeutic implications it is worthy of am philication This neuromuscular block is similar or identical with a phenomenon seen in the expenmental laboratory If the motor nerve to a muscle is stimulated, the muscle responds by a contraction As the frequency of stumulation rises, the rate of muscle response increases with it A point is reached at which stimuli no longer seem to excite the muscle which remains relaxed spite of this, the nerve-will still conduct and the muscle still respond to direct stimulation block appears to occur at some point between nerve and muscle, the myoneuml junction the frequency of stimulation of the nerve is now dropped alightly the muscle will again contract vigorously This neuromuscular block at critical frequencies of stimulation is known as the Wedensky inhibition Its exact nature represents one of the key mysteries of neurophysiology

Curare creates a like inhibition fortunately at frequencies which are lower and of clinical significance. The importance of this lies in its thera peutic applicability to many abnormalities of the neuromuscular system. Simplified to the utmost, these pathologic states, in part, resolve themselves

into alterations in the frequency and duration of impulse bombardment at the my oneural junction By maintaining certain concentrations of curare it is possible to create a differential block at the function and in effect filter the abnormal volleys At the same time lower rates of bombardment characteristic of voluntary innervation are still capable of initiating a muscle response. The Wedensky effect depends upon the maintenance of critically high frequencies. For an equally efficient therapeutic block with curare, it is likewise imperative that the entity under treatment be characterized by a relatively rapid or prolonged hombardment of the myoneural junction The entire rationale of treatment is based upon this concept and understanding it one can predict therapeutic response in a given syndrome

Success then does not imply paralysis of the myonoural junction but a differential blocking of abnormal innervation patterns imposed by the disease process. On this basis a sharp division may be made among its various applications 1 Where total or subtotal block is necessary

as in (a) surgical anesthesia and (b) shock therapy

2 Where partial block is desired as in (a) muscle spasm (b) spasticity and (c) rigidity We obviously are not concerned in this discussion with the total paralyzant effect but rather with the partial or lisave effect

The first problem encountered in attempting to set up a partial neuromuscular block with aqueous curare hes in its evanescent effect and narrow therapeutic margin The aqueous drug is characterized by rapidity of action and excretion. West 2 Burman, and others have described its use in syndromes exhibiting spasticity rigidity and involuntary movement. They noted demonstrable clinical reduction in abnormal activity effect, however was universally considered to be transient and of questionable therapcutic value In the treatment of neuromuscular syndromes of a chronic nature this has made the drug little more than a curiouty Because of the rapid absorption high blood levels are achieved for short periods of time, during which central and peripheral curare effects occur concomitantly Along with the desired relaxation classical signs of curarisation often appear. This seriously in terferes with therapy, especially in the ambula tory patient. Prolongation of the desired effect

Presented by invitation, at the 141st Annual Meeti g of the Medical Society of the State f New York Buffalo General Sessions, May 7 1947 The A. Walter Suiter Lectureship.

at designated levels is difficult or impossible to achieve

In an attempt to prolong the desired blood levels and action, and avoid the unpleasant sideeffects incident to uncontrolled concentration, various measures have been tried An oil-in-wax suspension has proved the most efficient 4 This preparation consists of a suspension of 3 per cent d-tubocurarine chloride in 48 per cent wax and The suspension is given intramuspeanut oil It yıelds a cularly, usually in the gluteal region fairly satisfactory slow-acting effect, lasting in some instances more than seventy-two hours and in all instances more than twenty-four dosages which afford good clinical response, unpleasant side-effects rarely occur The drug has been singularly free of toxic effects and has shown no tendency to disturb normal body economy or cause habituation or tolerance Statistically, spasm, spasticity, and rigidity are affected in order of decreasing efficiency Dosage requirements are complicated, and more strikingly related to disease entity and degree of motor activity than to body weight. The therapeutic response is directly related to the nature of the abnormality of neuromuscular innervation more nearly the disease state maintains a type of bombardment favorable to the occurrence of a Wedensky-type inhibition, the more exemplary the result Duration of effect seems also related to the same mechanism. In general, the more constant and rapid the motor activity, the more successful the therapeutic result, and the longer the duration of effect Statistically, these observations are borne out well There is, thus, a striking correlation between physiologic expectation and therapeutic response Prognosis within reasonable limits is possible in a given case

The data presented here are based on an analysis of more than 500 treated cases which fall into the following categories

#### A Muscle spasm

- Myositis, actual muscle trauma
- Reflex spasm in orthopedic disturbances, low back syndrome
- 3 Joint disease, arthritis

#### B Spasticity

- 1 Spinal cord injury
- 2 Degenerative diseases of the central nervous system, such as multiple sclerosis
- 3 Cerebral palsy
- C Rigidity, postencephalitic Parkinsonism
- D Dyskinesia
- E States resembling muscle spasm and spasticity as in poliomyelitis

All cases were studied clinically from the neurologic and physiotherapeutic points of view Analyses of function and motor efficiency were recorded at regular intervals. In addition, where feasible, electromyographic studies and motion pictures were done. Our final impressions are based on this material

#### A Muscle Spasm

The entity clinically designated as muscle spasm may be defined roughly as a state of transient muscle contraction not amenable to voluntary control, it is characterized by resistance to stretch and ordinarily is associated with pain. It is in large part a protective device, an attempt at splinting to avoid trauma and pain the picture is well recognized It may be a muscle response to irritation, inflammatory or trau-It may be reflex in origin and secondary to pathologic conditions, visceral, or somatic, of like segmental neural connection Wolff, and others have shown that this latter type of muscle spasm may be perpetuated after cessation of the initiating stimulus and, thus, present a major treatment problem

The various lesions which together make up the low-back syndrome are excellent examples of the importance of the problem of muscle spasm in treatment. The initiating trauma or etiologic agent is followed by muscle splinting as a protective measure. Pain enhances the splinting or spasm, which in turn is followed by more severe pain and further muscle spasm. The vicious cycle is self-perpetuating.

Dramatic relief may be afforded by any agent which tends to interrupt and break up the cycle of splinting and pain. There are many traditional measures, all of which have some rationale and serve their purpose, at times, admirably. These include heat, traction, ethyl chloride spray, novocaine, or saline injections, and heavy sedation. Unfortunately, none of these measures is specific or generally reliable in a series of cases.

Since curare is known to create a myoneural block, it is logical to try to apply its properties to the treatment of muscle spasm It has been consistently possible to break up muscle spasm and enhance recovery rate when the initiating pathologic condition is static or brought under control Where the pain and local muscle spasm are secondary to a continuing stimulus, 1 e, root compression, radicular pain persists after reduction of the spasm and the local or reflex spasm often recurs shortly This response may prove to be a useful diagnostic test Relief of muscle spasm ordinarily is followed by abrupt relief of local pain and its reference However, where root compression, such as in hermation of the nucleus pulposus, is the exciting and continuing stimulus, the relief of local muscle spasm does not influence the severe pain and actually may highlight its segmental nature by removing temporarily the purposeful splinting action of the muscle spasm

The cases studied run the gamut of low back disorders, including the usual orthopedic disturbances, so-called low-back strain, osteo-arthritis of the spine, acutal vertebral lesions, disk lesions, and also some instances showing reflex spasm secondary to remote disease.

It is apparent from the results that in many cases of low back syndrome an abrupt cessation of the major complaints often follows upon relief of muscle spasm The sequence of events after treatment is of interest The patient usually notes an abrupt relief of major pain within several hours after injection. Mobility is increased and the patient describes a feeling of pleasurable relaxation, even drowsiness. The severe pain is followed by muscle soreness and localized pain in the region of actual disease, if it is capable of local signature. The soreness is a logical sequel since protracted muscle contraction is associated with diminished vascular exchange and ischemia It is known that, depending upon the chronicity of the process the muscle involved may thus show reversible inflammatory changes, cloudy swelling etc. The characteristic tenderness which remains even after complete relief of pain "coms to have its basis in this transient pathologic state

The flexion deformities which develop about diseased joints are well known. They represent a protective splinting device and an attempt to prevent further joint injury These conditions are reversible if treated early but if allowed to perent they inevitably go on to contracture and static deformity Striking atrophy of the opposing extensors occurs as is so often seen in the quad nceps group in disease of the knee joint. This is due to the prolonged reciprocal inhibition of the extensors while the flexors are in constant contraction, and is followed by true atrophy of the flexion deformity by relaxation of the contracted muscles permits adequate range of motion and chronic shortening is not allowed to occur The final result when the diseased process is burned out need not be accompanied by empling, secondary neuromuscular deformities. It is here that the relaxant effect of curare, along with in telligent physiotherapy, may have a real and post tive role.

#### B Spasticity

Spastiaty is characterized by increased excit ability of the stretch reflex. Motion, passive or active is accompanied by reactive muscle contraction of abnormal intensity which interferes with efficient motor function. No adequate measure has yet been described which will alleviate the discussion of the condition with complete success. Surgical procedures,

such as neurectomy or muscle-cutting operations take a toll in reducing motor power. In such cases an attempt is made to saturate the patient with curare at levels which do not interfere with voluntary function but reduce the hyperactivity of the stretch reflex. With good reduction in stretch excitability the patient's voluntary power is unmasked and retraining made possible in order to rebuild muscle volume and useful habit patierns. Without such reduction, physiotherapy increts acts as a simulant to reflex activity. The place of intelligent rehabilitation once spasticity is reduced can not be overstressed.

Cerebral Palsy - In his monograph on disorders of the central nervous system in children, Crothers' states it is essential to develop every motor asset in sight. This conservation and development of assets is procured by two different but closely coordinated methods First and always, by training and second by procedures which avoid or correct contractures" Achievement of both these objectives is facilitated by the use of curare in oil Training capacity is enhanced markedly by the reduction of abnormal activity, with a consequent increase in motor The same reduction in spasticity or efficiency abnormal muscle tensions also allows a range of motion and activity which prevents further fixe tion deformity or contracture Unlike surgical procedures designed to this and it is unnecessary to destroy innervation or reduce the number of functioning motor elements contributing to the deformity Effective diminution in abnormal motor activity can be obtained without perceptable loss of motor nower

One has only to watch these children at school to realize the titanic effort which goes into every attempt at motor performance. In light of this the degree of their achievement under this form of therapy might seem slight to the casual observer Nevertheless by objective per formance standards the improvement in motor performance is strik The same tremendous drive which characterizes their usual effort now pushes their perform ance levels forward at rapid rates. The final result again depends upon the manner in which the physiotherapist takes advantage of the reduction in spasticity It should be pointed out that all cerebral palsy cases do not exhibit pure spastic-The therapeutic results with curare are in direct ratio to the part played by spasticity as opposed to involuntary movements and dyskinesia.

#### C. Rigidity

Evaluation of treatment in these cases is most difficult. It can be stated definitely that rigidity is an indication tremor is not. Rigidity associated with extreme discomfort immobility, and beginning contracture can be alleviated partially

Sleep is usually improved Pain associated with long-standing muscle tension can be influenced to a gratifying degree In rigidity there is, however, a wide disparity in response and in dosage tolerated Where amelioration of rigidity occurs, the physiotherapist can add a great deal to the patient's comfort and motor efficiency by taking advantage of the decrease in abnormal muscle tension

## D The Dyskinesias

In conditions characterized by abnormal involuntary movements, such as dystoma and athetosis, the results are disappointing. This is to be expected on the basis of the pathology and type of motor management in these conditions. At times it is possible to reduce the amplitude and force of the involuntary movements so that reeducation can be attempted and carried out. However, the results are not of the same order as in muscle spasm and spasticity.

# E States Resembling Muscle Spasm and Spasticity, as in Poliomyelitis

The treatment of acute and subacute anterior poliomyclitis consists largely in the alleviation of symptoms and the prevention of deformity and loss of motor function. The fact that there is no specific therapy perhaps throws undue emphasis on forms of symptomatic relief.

During the early phases of the disease or acute febrile illness, meningeal inflammatory reaction occurs, accompanied by root irritation followed by what appears to be a muscle spasm Meningismus is followed by protective splinting of the erector spinal and thigh muscles to avoid painful stretching of neural elements Certainly root irritation is capable of initiating hyperesthesia and reflex muscle spasm tion, there may be actual inflammatory reaction in the muscles per se characterized by pain and tenderness, muscle shortening, and resistance to A similar picture is seen in acute rheu-Spasticity can also be elicited matoid arthritis at times and seems to be present when the muscles are studied electromyographically definition and mechanism of these states resembling spasm and spasticity are not completely clear The similarity of the clinical picture to true muscle spasm and spasticity makes a trial of curare a rational procedure Although the results to date have been encouraging, the final answer will have to await much further careful and controlled studies

It is obvious that a suspension of curare of this kind is potentially dangerous. Certain strict precautions must always be maintained. In spite of these, the possibility of rapid curare intoxication should be kept in mind. In our series of 500 cases.

more than 5,000 consecutive injections have been given without alarming side-effects. After an initial trial period, during which the patient is hospitalized, if possible, the patients have been kept on maintenance levels as ambulatory outputients.

The side-effects we have seen are of great in-They may be divided into those representing a concentration of curare high enough to cause paresis and affect autonomic and central synapses, and those which are true side-effects The first group may be identified with the classic picture of curarization and needs no discussion The outstanding effect of the second group is a histaminic or histamine-like response tient notes pounding headache, along with heat and flushing of the limbs Dizziness and cold sweat are seen, as well as transient fall in blood These reactions occur in 10 per cent of pressure cases and are usually of mild order, and do not per-Antihistamine drugs, such as benadryl or pyrabenzamine, have proved of no value in preventing these side-effects

We have seen no tolerance develop and no increase in sensitivity to curare. Certain disease entities are strikingly sensitive to the drug. These include myasthenia gravis and, to a lesser degree, amyotrophic lateral sclerosis. Other states, particularly spastic paraplegia, can tolerate enormous doses without untoward curare effects.

#### Conclusion

On the basis of our experiences in a fairly large series of cases, we have concluded that a longacting suspension of curare represents a useful tool in the treatment of muscle spasm and spasticity The physiologic implications of its mode of action are of great clinical and experimental in-Knowledge of the basic mechanisms involved is likewise helpful in predicting therapeutio effects Throughout our studies the importance of well-planned rehabilitative physiotherapy has been high-lighted Curare alone merely reduces the abnormal neuromuscular patterns remains for the intelligent physician to take advantage of this reduction in order to rehabilitate the patient and prevent unnecessary crippling deformity

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#### DIVERTICULOSIS AND DIVERTICULITIS OF THE COLON

Review of 99 Cases

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IVERTICULOSIS is commonly seen in persons past middle life, but diverticulitis or an inflammation of these diverticula, is a comparatively rare disease. It probably can be assumed that approximately 1 per cent of the entire population has a diverticulosis. The majority of diverticula develop later in life and are probably the result of a mucosal herniation at the point of entrance of blood vessels into the wall of the intestine. Smithwick has estimated that approximately 5 per cent of people over 40 years of age have diverticulosis.1 Of this group he estimates that approximately 10 per cent subsequently will develop diverticulities and, of these, between 20 and 30 per cent will require surgical treatment. Ochsner and Bargen reviewed a large series of cases and reported diverticulosis as frequently in women as in men? They stated that diverticulous was rarely seen before the age of 30 years and that the incidence of diverticulities increased slowly in each half decade until that period between 55 to 59 years which marked the peak of incidence for each sex

It is generally agreed that the treatment of uncomplicated diverticultis is usually a medical problem but when complications such as per foration, peritonitis peridiverticulitis fistula formation, or intestinal obstruction develop surgery may be necessary. In a series of 227 cases of diverticulitis reported by Rankin and Brown, 48 or 21 per cent, required surgical treatment. Operation was performed in 99 or 26 per cent, of 376 cases of diverticulitis reported by Brown and Marcley. Other series have shown a comparable incidence of cases requiring surgical treatment.

Another point that is gradually becoming established, as has been pointed out by one of us (Stalker') elsewhere, is that an association between diverticulitis and carcinoma is very rare so rare that one might even suspect that the presence of diverticulous protects a patient from the coming of canner. In a series of 227 cases of diverticulitis reported by Rankin and Brown co-existing carcinoma was found in only four in stances? These same writers reported coexisting diverticulitis in only 4 of 679 cases in which operation was performed for carcinoma of the colon. Fallon noted while studying cases of diverticulitis at the Mayo Clinic, that carcinoma

coexisted in only 0.5 per cent. These authors felt that in as much as the sigmoid is the most frequent site for carcinoma, as well as diverticulities of the color their occusional simultaneous occurrence would be expected. The relationship between the two is incidental rather than actual

#### Review of 99 Cases

We have recently reviewed 99 consecutive cases of diverticulosis with or without diverticulitis. The diagnosis was confirmed in all instances by either roentgenologic examination or operation. Of these cases, 43 were admitted to the hospital as surgical problems and 56 as medical problems. The diagnosis occurred almost equally in the two sexes, there being 53 women and 46 men. The average age of the patients was 62 years the youngest being 23 and the oldest 82. In all instances when diverticulitis was present the patient was more than 40 years of age.

In 47 of the 99 cases, diverticulous was found as an incidental finding at the time of roentgenologic examination of the colon. There were few if any symptoms which could be held referable to the diverticula, but a few cases gave a history of past disturbances suggestive of mild attacks of diverticulitis. The symptoms and findings were in agreement with the diagnosis of diverticulitis in 52 of the 99 cases

Thirty-seven of these cases were uncomplicated and were successfully treated medically The symptoms presented frequently were analogous to those of appendicitis with the exception that they were left-sided rather than right-sided Pain usually localized in the left lower quadrant of the abdomen, was the most common and pronounced symptom This was often cramping and intermittent in character and occasionally extended to involve the entire abdomen or radiated to the back Gaseous distention was noted frequently and the pain was commonly relieved by a bowel movement. Nausea and vomiting were not uncommon, and a change in bowel habits either constipation or diarrhea, occurred frequently Bloody and tarry stools were uncommon A slight fever and leukocy tosis were usually present Tenderness, sometimes with spasm over the sigmoid was the cardi nal finding. In some cases a mass could be palpated These symptoms were all intensified when a complication, such as perforation, was present

Fifteen cases were treated surgically, because one of the previously mentioned complications existed. In many instances, as has been the case in other reported series, the preoperative diagnosis was incorrect. Four were diagnosed as appendicutes, 3 as intestinal obstruction, 2 as ruptured diverticula of the colon, 2 as carcinoma of the colon, and 1 each as a ruptured ovarian cyst, a twisted ovarian cyst, a pelvic abscess, and an ectopic pregnancy.

The operative findings revealed perforation with or without abscess formation in all cases An inflammatory mass was invariably present The treatment instituted was for the most part In 6 cases, drainage alone was conservative performed In 2, a temporary colostomy, and in 4. two-stage Mikulicz procedures were carried In 2 cases a primary resection with anastomosis was performed, and in 1, an abdominopermeal resection Three patients died postoperatively, but the immediate results were satisfactory in all other instances. One death occurred following a resection with anastomosis, another followed simple drainage, and a third followed a pulmonary embolism

Two cases which tend to illustrate a few of the problems presented by the surgical group are reported

Case 1 —A man, aged 74 years, was seen twentyfour hours after he had developed cramp-like pains in the lower abdomen which were referred to the epigastrium. There was nausea and vomiting. He had been unable to defecate and the abdomen had become markedly distended His temperature was There were 11,000 leukocytes 101 F A tender. relatively fixed mass could be felt in the left lower quadrant of the abdomen A sigmoidoscopic examination to a distance of 24 cm revealed no abnormal findings Roentgenologic examination showed an obstructing lesion in the lower sigmoid An occasional diverticulum was associated with this defect, and it was felt that it was characteristic of diverticulitis

At operation a lesion more suggestive of carcinoma than of diverticulitis was found. A two-stage Mikuliez type of resection was performed and pathologic examination revealed multiple diverticula with diverticulitis. The mucosal lining of these diverticula showed no cancer, but a few millimeters away from the opening into the largest diverticulum was an ulcerating adenocarcinoma.

Case 2—A woman, aged 59 years, was admitted to the hospital because of nausea, vomiting, and constant left lower abdominal pain associated with intermittent chills and fever. An appendent omy for these symptoms had been performed elsewhere twelve weeks previously. Examination revealed an ill-appearing woman who had a firm, tender mass

filling the entire pelvis, and, in addition, a huge mass which filled the entire right abdomen Roent-genologic examination revealed a mass in the upper abdomen causing downward displacement of the colon and elevation of the right diaphragm.

Abdominal exploration was performed, and a huge, simple cyst involving the entire right lobe of the liver and filling the entire right abdomen was found. At least 4,000 cc of clear fluid was evacuated from this cyst and the cyst treated by marsupialization. There was a huge inflammatory mass involving the lower portion of the sigmoid which felt like a perforating carcinoma.

In view of the history, the possibility of diverticulities could not be excluded, and a loop of transverse colon was brought out as a colostomy. The patient made an uneventful convalescence. The cyst of the liver has completely disappeared. Subsequent roentgenologic examination has demonstrated the mass to be an area of diverticulities.

The patient is having so little trouble from her colostomy that she has preferred to keep it rather than to have a closure or a resection attempted

#### Comment

There is no question in our minds that many more cases of diverticulosis than have been recorded were observed during the period that this review represents In order to obtain these, it would be necessary to go to the v-ray records to find out how often diverticula are found as compared with diverticulities Many of us never make notes on the diagnostic master sheet of diverticulosis, and, hence, any quotation of statistics obtainable from a record department would be most misleading We believe that this point has often been overlooked and, as a result, many unfair statistics have been published interested only in the problem of diverticulities as it pertained to the sigmoid colon, and, for this reason, no cases involving other portions of the gastrointestinal tract have been included in this

It is not fair, without some explanation, to state that in many instances the preoperative diagnosis was incorrect. In all of these cases the possibility of a complication of diverticulitis had been considered, but in view of the serious illness, roentgenologic examination of the colon could not be carried out. In most of these cases it was usually the first attack and the onset had been of a relatively short duration. In a few there were other associated surgical conditions. The tendency seemed to be to decide to operate on the basis of the frequent diagnosis of "acute abdomen" or because of the presence of obstruction.

The complications of inflammation and obstruction are the major indications for the surgical treatment of diverticulities. A direct surgical approach to an inflammatory process, such as

diverticulits, carries a mortality rate much greater than 35 per cent in contrast to a mortal try rate of from 5 to 10 per cent in the treatment of a noninflammatory lesion. It is obvious that as much conservation as possible should be excessed in the surgical treatment of these conditions. We feel that when more than drainage is necessary, an artificial colonic stoma should be first established. Then, after a few months, depending on the patient s progress, the diagnosis a persistence of the deformity and other factors a resection may be indicated.

Many of these problems were illustrated by the 2 cases reported. In each of these cases it was impossible either preoperatively or at operation to differentiate between carcinoma and divertic ulitis. A primary colostomy would have been performed in the first case had it not been possible to exteriorize the mass without much difficulty The finding of both carcinoma and diverticulities was coincidental. In the second case we felt almost certain that we were dealing with a perforating carcinoma but the response and examinations following a transverse colostomy have confirmed a diagnosis of diverticulities. In another case the surgeon felt so certain that he was dealing with carcinoma that an abdominoperment resection was performed. We feel that if cancer is to be coped with intelligently one cannot be too critical of this mistake

Although these 99 cases have not been fol

lowed for a sufficient period of time to be specific certain general observations have been made. A few of the cases of diverticuloss have developed diverticulitis. Approximately one third of the cases of diverticulitis treated medically have continued to have some trouble. The same results were obtained in those cases treated surgically.

#### Summary

A review of 99 consecutively treated cases of diverticulous with or without diverticulius has been made. Forty-seven of these were diverticulous and 52 diverticulius. There were 37 cases of uncomplicated diverticulius which were treated medically. Complications existed in 15 cases and surgical treatment was required. The association of diverticulities and carennoma of the colon is coincidental. Two cases which demon strated the difficulty of clinical differentiation between these conditions were reported.

MEDICAL ARTS BUILDING

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## CZECHOSLOVAKIA HONORS AMERICAN DOCTORS

Five New York doctors will receive the Order of the White Lion, highest honor of Czechoslovakia. They are among 14 American doctors who will receive the honor for work done last summer as members of the Unitarian Service Committee Medical Teachur, Mission and Czechur, Mission a

Teaching Mission.

The New York doctors are Dr Alexander Frunschwig, clinical professor of surgery at Cornell Medical School and attending surgeon at Monerial Hespital Dr Leo M Davidoff attending neurological surgeon at Monteflore Hospital and professor of neurosurgery at Columbla Unity raity, College of Physicians and Surgeons, Dr L Emmett Holt Jr chairman of the pediatrics department of New 1 ork University and director of pediatric service at Bellovue Hospital, Dr C M MacLeod, chairman of the bacteriology department of N Y U College of Medicine and chief of the preventive medicine section of the Office of Scientific Research and Dovelopment and Dr E. A Rovenstine, director of anesthesia at Bellovue Hospital, and professor of anesthesia at N Y U

## JOINT SERVICE URGED ON DOCTORS DENTISTS

One hundred members of the American Academy of Dental Medicine attended the first annual meeting of the group in June, in the George Washington Hotel.

The physical welfare of patients requires 'not overlapping but integration of dontal and medical health service stated Dr Walter Henry Wright, dean of the New York University College of Dentistry

Diseases requiring the services of both dentist and physician would be brought under control in less time, with less suffering, with less cost to the patient, if dentists and physicians would regard the patients a single instead of a multiple health problem.

It would be difficult to outline the respective sones of influence of the dentist and physician Dr Wright declared adding. It is not uncommon that physician have extracted teeth for alleviation of systemic disturbances or that dentists have administered systemic medication for the relief of dental diseases. It is an othical duty to give the patient the benefit of a modern integrated health service.

## ANTIHISTAMINE DRUGS IN ASTHMA AND HAY FEVER

DAVID LOUIS ENGELSHER, M D, New York City

LMOST yearly new drugs and methods are 1 prematurely offered to physicians and the laity via periodicals, radio, and drug store media, with exaggerated claims for the cure and relief of asthma and hay fever

In previous years, we have had potassium chloride, ascorbic acid, and aerosol penicillin upon which I reported unfavorably 1-3 in spite of the marked enthusiasm for them at the time Histamine, nasal ionization, and phenol cauterization must also be mentioned for their initial enthusiasm

This year the antihistamine drugs, benadryl and pyribenzamine, are foremost Striking scientific reports. 4-6 with their fervor fanned by the lasty press and radio commentators, have produced an unprecedented demand, in my opinion, unwarranted by the following facts Initially, I desire to offer a word of caution The drowsiness which occurs in a considerable percentage of cases is at times so marked as to interfere with the ability to continue one's work This effect on car drivers, machine workers, and others may prove a source of danger to themselves and others This caution should be emphasized

The proof of results is not in animal statistics, but on the patient There are certain criteria which must be used, to evaluate a remedy prop-In New York City, the peak of hay fever suffering usually is Labor Day and Labor Day This period is, clinically, the most concentrated time of ragweed symptoms sions drawn before that time are not accurate since, spontaneously, the symptoms vary extremely during the day Any type of favorable conclusion may be drawn, even from a placebo In addition, a large enough number of cases of a severe persistent type, over a period of two years. and preferably those known to the physician are the other factors necessary for a proper appraisal The reason I state two years of observation is because one year the hay fever season may be comparatively mild as, for example, the ragweed season in New York City in 1946 That season was not as severe, in a general way, although in some cases, suffering was intense

With the preceding factors as a background, I studied the effects of the antihistamine drugs (benadryl and pyribenzamine) on 193 cases of simple, multiple, and mixed forms of asthma and hay fever on patients I had known for a number of years Ages varied from 3 years to 79, sexes were about equally divided, and occupations included housewives, office workers, teachers, physicians, dentists, pharmacists, students, outdoor workers, mechanics, and retired persons

It must be remembered that the symptoms of hay fever are not necessarily alike in all patients In some, sneezing predominates, in others, nasal obstruction or rhinorrhea, eye, ear, or throat complaints are severe in many people study, if the antihistamine drug stopped the sneezing or rhinorrhea, and resulted in nasal clogging, often to prevent sleep, it was not recorded as an improvement The patient would rather have a wet than a dry clogged nose noted such a result as poor Another observer may classify the effect as satisfactory or good because it stopped the sneezing

The above 193 cases were given benadryl and pyribenzamine for a three-day trial One hundred and twenty-seven, roughly two thirds, were either unrelieved or aggravated, because of the drying effect, resulting in cough and asthma in some patients who never before had chest symp-Of the remaining one third, some were definitely improved (9 per cent) and others somewhat better None of the severe cases of asthma was convincingly relieved, most benefit occurred in urticarias

Comparing the antihistamine drugs to our standard pharmaceuticals used in various synergistic combinations, such as ephedrine, epinephaspirin, aminophylline, phenobarbital, codeine, iodides, and others, the new drugs fail by far, in effectiveness in allergy conditions of the respiratory tract I have already mentioned the marked side-effect of drowsiness, dizziness, headache, nausea, and vomiting were also observed

If a procedure could be formulated, voluntary or legal, by drug manufacturers, lay publications, and radio commentators to defer extolling "new cures" for asthma and hay fever (also other disea es), until such time as scientific medical reports definitely affirm their value, the medical profession and drug trades would be saved repeated embarrassment and loss of prestige, and the public a fortune and disappointment

At this time, it is my opinion, that although the antihistamine drugs may be of fair to striking value in a small percentage of hay fever and asthma cases, the vast majority are not convincingly benefited, in asthma, the percentage is of negligible import, and does not compare in value with our standard drugs and procedures

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#### CONFERENCES ON THERAPY

DEPARTMENTS OF PHARMACOLOGY AND MEDICINE CORNELL UNIVERSITY MEDICAL COLLEGE AND THE NEW YORK HOSPITAL

THESF are stenographic reports of conferences by the members of the Departments of Pharmacology and of Medicine of Cornell University Medical College and New York Hospital with collaboration of other departments and institutions. The questions and discussions involve participation by members of the staff of the college and hospital students and visitors. A selected group of these conferences is published in an annual volume Cornell Conferences on Therapy by the Macmillan Company The next report will appear in the October 1 issue.

#### The Treatment of Alcoholism

Dr. HAROLD G WOLFF We will consider today the problem of alcoholusm. It is difficult to deter mine the extent of this malady It has been con rervatively estimated by Kolb, of the United States Public Health Service, that perhaps two and one-half million people in the United States are addicted to alcohol to a degree that in some way interferes with their effectiveness and the ful fillment of their potential It is thought by Kolb also, that approximately 200,000 of these are seriously sick—and the problem of helping them has not been solved Dr Rennie will open the discussion

Dr. Thomas A. C. Rennie From 10 to 25 per cent of admissions to state hospitals are for conditions associated with alcoholism. In addition alcohol runs very high as one of the major causes

of psychoses

There is a growing awareness, fortunately of the fact that alcoholism is a disease not a weak ness of character, and that the alcoholic represents a human being who is escaping from intolerable stresses or strains Hence there is a very large emphasis now on psychotherapy in the treatment of these individuals. Satisfactory treatment is not yet the rule however From a manuscript just released representing a year's study by the Committee on Public Health Relations of the New York Academy of Medicine come the fol lowing rather interesting facts which point to the dearth of facilities for the treatment of the alcoholic. The figures are based on 1 609 replies to a questionnaire which was sent to several thou sand practicing physicians in Now York. Chronic alcoholies are treated by about 75 per cent of the psychiatrists who replied, by about 50 per cent of the general practitioners and by 46 per cent of the internists. They all said they treated some alcoholics however only 04 per cent of those replying said they treated more than 10 per cent of their total practice for problems of alcohol or in other words made any sort of specialty of that problem in treatment. The percentage treating the acute alcoholic was about equal for the psychiatrist the internist, and the general

practitioner with a slightly heavier weighting for the internst

The methods used in treatment ran a strange gamut of performances The largest number of physicians stated that they used psychotherapy A number of them who were questioned as to what they meant by that had great difficulty in explaining what psychotherapy meant most common form of treatment was hospitalization (when it was possible to get a hospital bed) Other forms of treatment relied heavily upon nu tritional aspects massive doses of vitamins, sedatives in one form or another Some physicians. not psychiatrists, mentioned that they used group psychotherapy Others stated that they used electric shock therapy a few that they used conditioned reflex therapy, although few were able to describe what conditioned reflex therapy was Among the psychiatrists about 40 per cent referred patients to Alcoholics Anonymous and about 23 per cent referred patients to various social agencies in the community

It is difficult to get an alcoholic patient into a hospital in this area, and it is a problem through out the country as well According to the an swers to the questionnaire the largest number of patients go either to Bellevue or Kings County hospitals both of which have psychiatric divisions and accept alcoholic patients the next largest number go to the Doctors Hospital the next to the Towns' Hospital and from there down.

Since 1945 all the municipal hospitals in the City of New York have been accepting alcoholic patients and putting them on the medical services only a few have special wings for the treatment of alcoholica

The knickerbooker Hospital about two years ago set ande 15 beds for the treatment of alcoholics referred by and in contact with Alcoholics Anonymous In the last five years from 8 000 to 12 000 patients per year entered Bellevue and New York municipal hospitals for alcoholism, their average stay being less than seventy-two Often they come in at night and go out in the morning. It is apparent that hospital

facilities for the treatment of this great problem are inadequate

Since psychologic factors in alcoholism are now being stressed, the psychiatrist's definition and classification of the alcoholic should be of interest as well as of importance in the treatment of the alcoholic. What is a chronic alcoholic? He may be defined as an individual who is unable to do without alcohol, who is completely and daily dependent upon alcohol for his comfort, and who is apt to take his first drink early in the morning of each day. He is a person who cannot function harmoniously or contentedly without alcohol

We recognize two large groups of chronic alcoholics—the "spree" drinker and the "steady" drinker. The spree drinker presents a special kind of psychologic problem—He is a man who may not drink for months at a time, and then goes off on a spree or "bender". This may last one day to a week or two, during which he drinks extremely heavily, often locking himself in his room refusing to see people—He comes out of the "spree" a few days or a week or so later, and has no desire for alcohol again for perhaps weeks, or months, or even years

The steady drinkers, however, are persons who have to have alcohol every day, and these are usually divided, in an attempt at classification, into four major categories One is that of the individual who has intolerable problems in his life knows what they are, but he cannot meet them with comfort, and he finds solace in alcohol second is that of the so-called psychoneurotic individual whose difficulties, problems, and conflicts he largely within himself, often unknown to him, and who finds that alcohol relieves the intolerable conflict The third category is that of the person who uses alcohol as a symptom of a more fundamental underlying psychiatric disorder Thus, we see patients in depression turning to alcohol, manies turning to alcohol to cele-Schizophrenic patients and the feebleminded are also easy prey to alcohol The fourth category is that of individuals in whom the personality component is not immediately striking, who just regularly and persistently take alcohol because they like the taste and effect of it

The treatment of the psychologic factors which lead to acute and chronic alcoholism, of course, cannot be considered here in detail. There are, however, clinical problems arising out of these conditions which demand immediate treatment. Let us consider these clinical problems in the management of acute alcoholism. I shall not burden you with the details of the picture of acute alcoholism for you all have seen it. It is usually self-limiting, harmless, and apt to be slept off quite satisfactorily, however, coma can intervene in an acute alcoholic spree and may require intensive treatment.

Great reliance is now being placed upon two major aspects of treatment. These stem from the more recent advances in the knowledge of the metabolism of alcohol. It is oxidized in the body rather slowly, about 10 cc per hour, this is best accomplished in the presence of insulin and glucose which facilitate its oxidation in the liver Vitamin B fractions, particularly thiamin and nicotinic acid, are also of value in this respect

Almost all treatment for acute alcoholism, delirium tremens, and other acute alcoholic conditions include the combined use of glucose and in-Usually 1,000 to 2,000 cc of a 5 to 10 per cent solution of glucose is given intravenously, together with 20 or 25 units of insulin, given sub-To this there is usually added, also cutaneously by the parenteral route, 50 to 100 mg of thiamin chloride and 100 mg of nicotinic acid levue Hospital 100 mg of ascorbic acid, as well as 5 mg of riboflavin by mouth per day is given that institution they also add 100 mg of pyridome to the regimen, in the belief that it may reduce the vomiting which so commonly is part of the picture of acute alcoholism Alcoholics require a high caloric diet with large amounts of protein as well as of carbohydrate It seems evident, therefore, that adequate nutrition with vitamin supplementation constitutes the backbone of the treatment as well as of the prevention of theserious sequelae of alcoholism

There are, however, additional important aspects in the care of the comatose, alcoholic patient He should be kept warm, turned frequently to prevent pneumonia, and given stimulants, if If the respiration is depressed semously, carbon dioxide and oxygen mixture may be Large amounts of fluids with electrolytes are required because alcoholics usually lose a considerable amount of fluid and sodium chloride in vomitus and diarrhea Every patient, of course, deserves a meticulous physical examination so that fractures, brain injuries, diabetes, and uremia, are not overlooked The only real dangers. usually, are those of circulatory collapse or pneumonia

Dehrium tremens presents different problems for treatment. The delirious react with great fear and panic, have visual hallucinations which are terrifying, and which are usually confined to small animals and bugs. There is disorientation, the patient does not know where he is and cannot grasp the significance of the environment about him. There is a characteristic tremor which gives rise to the name of the disorder. Delirium tremens is, also, usually a self-limiting disease, running anywhere from one to five or six days, with almost invariable recovery.

For its management it is preferable that these patients be put in a hospital Good nursing care is important. The patients are frightened and

need constant reassurance They find it difficult to orient visibly and should be kept either in a room brightly lighted or in one completely dark. Because they are disoriented and confused, they frequently mustake windows for doors, and a serious accident or inadvertent suicide therefore, should always be guarded against

Hydrotherapy is used commonly in the acute case of delirium tremens. The rest of the treatment is largely supportive. Treatment includes the use of vitamins, sedatives, and the insulin and glucose combination, already mentioned. The most commonly used sedative is paraldohyde. It to 20 cc by mouth or in smaller doses intra muscularly if the patient is unable to take it orally. Chloral hydrate is also used in 0.5- to 1 Gra, doses, and more rarely the barbiturates particularly sodium amytal in 0.25- or 0.3-Gm doses. Some physicians do not use barbiturates in alcoholics because they fear the development of dependence.

These patients also need large amounts of fluid and sodium chloride Routine care also includes a high calone diet preferably fluid (often delirious patients are not able to tolerate solids because of persistent gastratis), and large amounts of car bobydrate and protein. In about five days the patient usually recovers without sequelae One danger in delirium tremens is that of circulatory collapse. Subslightalization is sometimes carried out if there are signs of cardiac distress so that the patient can be digitalized more rapidly if it should become necessary

There are a group of disturbances which result from, or are associated with the long-continued use of alcohol which I have time only to enumer ate but of which we must be aware acute alcoholic excitement, pathologic alcoholism with epileptoid manifestations acute or chronic hal lucinosis alcoholic deterioration jealousy and paranoid reactions Korsakoff's psychosis and the Wernicke syndrome. Many of these are pri marily vitamin deficiency disorders only secondarily due to the use of alcohol These complica tions develop because of poor appetite deficient food intake and the vitamin inadequacy that almost invariably accompanies it Their treatment involves restoration of vitamins by massive doses, either orally or hypodermically over a long period of time Some of these disorders do not clear up rapidly even though the vitamin defi ciency is treated

Finally, we come to the problem of the chronic alcoholic the psychologic types of which I have already defined. The chronic alcoholics are best treated in a hospital although very few of them are willing to accept that formulation. Hospital intion removes the alcoholic from all sources of alcohol. In the hospital he is separated from an

environment which is stressful. It is a neutral environment in which the nursing staff as well as the physicians are understanding of his problems. The psychiatrist has the opportunity to observe his day by-day reactions and his responses to other patients, to analyze his anxiety reactions as they occur, and to proceed much more rapidly with the psychotherapeutic exploration. For these reasons, hospitalization is desirable—hospitalization for a fairly protracted period a minimum of three and preferably, six months or longer

In New York State it is not possible to commit alcoholies. Revision of the laws of the State to make this possible should be given careful consideration because one of the great difficulties with the complete treatment of chronic alcoholics is that usually four to six weeks after alcoholics have stopped drinking they attain a state of mild ouphorm, and think they have solved their problems and no longer need to go on with therapy If they demand it, they must be released from the hospital Alcoholics can petition for a voluntary In such a case hospitalization can commitment be ordered by a judge and the patient kept in a hospital until cured although at some earlier time he may desire to leave

The first problem of course, is to get the alcoholic to stop drinking At Payne-Whitney we withdraw alcohol immediately. We feel that there is no valid psychologic reason for a tapering off procedure Removal of alcohol requires strong reassurance suggestive measures attention to dietary needs and sedation if discomfort is great Prequently hydrotherapy is the best form of nonchemical sedation The second major problem is through self-analysis to get the man to understand the primary causes of the emotional distress that lies within his own personality He eventually may attain complete insight into the forces which so commonly are subconscious and which he does not usually or easily recognize

Several other procedures are of sufficient value to merit mention. There has been a growing in terest in the past few years in a process called conditioned reflex or conditioned-aversion therapy which was developed on the West Coast and is used in several hospitals today It consists of the injection of 0.25 to 1 cc of a mixture which contains, in each ce 75 mg of emetine and half as much pilocarpine and ephedrine Ав уон сал imagine it produces violent nausen. The injection is given to the patient together with alco-Treatments are given once a day for three to seven days Reinforcement single treatments are given at the end of one month and two months and following that at three-month intervals for a year The Washingtonian Hospital in Boston which is one of the few hospitals

in this country devoted exclusively to alcoholism, claims excellent results from that procedure, having as high as 70 to 80 per cent of cures as measured by abstinence for periods of two or three years

One of the large private hospitals in this area stated that 25 per cent of their cures of alcoholics was accomplished through Alcoholics Anony-Indeed, so important is that organization that every physician should be aware of what it does, and how they can get help from it holics Anonymous is an organization of nondrinkers, all formerly alcoholics, banded together some twenty years ago, now numbering 25,000 members in 750 cities throughout the entire world They are dedicated to the cure of alcoholics the request of any alcoholic patient they go to his home, get him to a hospital, and stay with him through his hospitalization. When he gets out they find a job for him What is still more important, they provide for him what is so difficult to provide for the alcoholic, a social environment in which alcohol does not figure as a major tool of release and relaxation Alcoholics Anonymous is an extremely important development in the treatment of alcoholics which should be drawn upon much more

Few general practitioners are aware of the extent to which social service workers' organizations can be helpful in the total problem. They can help in providing hospitalization, they can provide jobs, they can provide support and reassurance throughout very difficult periods. They are far too little drawn upon by the general practitioner.

I have told you of the dearth of facilities in this area and the dearth that exists throughout the country Obviously, what is needed are more provisions for the medical treatment of this vast group of disabled people. There is a growing conviction that their treatment lies primarily with the general practitioner, the internist, and not so much with the psychiatrist, and that ideally facilities for the treatment of these individuals should be set up in general hospitals, not in psychiatric hospitals. Another important development is the establishment of outpatient services such as have been evolved at the Yale Medical School (The Yale Clinic Plan)

Finally, we must recognize it as a truly great public health problem, the importance, the magnitude, and the requirements of which must also be brought to the attention of the public. In our social planning for alcoholics, we lag far behind that which is already under way in Sweden and Switzerland. There they have local temperance units in all the small cantons and small communities. Immediate emergency help is available

and the patients are referred to appropriate sources for additional help. This type of social planning has shown little evidence of emerging in the United States

For those who want more specific help with the management or understanding of these problems there are now three national agencies concerned with the treatment of alcoholism. One is the Research Council in Problems of Alcohol, a national organization in New York devoted to the aspects of research into the causes and prevention of alcoholism. Another is the National Committee for Education on Alcoholism, also in New York, and the third, the National Committee of Alcohol Hygiene, is located in Baltimore

DR WOLFF Dr Rennie, in referring to the management of the acute alcoholic you spoke about the use of stimulants What did you mean specifically?

DR RENNIE The one most commonly used is caffeine sodium benzoate, 0 5 to 1 Gm Another fairly common one is benzedrine sulfate, 5 and 10 mg

DR CARY EGGLESTON Circulatory rather than cardiac stimulants?

DR RENNIE Yes

DR WOLFF Is anyone convinced that giving vitamins to a person in the acutely alcoholic state could be effective in the short time that the individual remains in that state? I take it that it would be a matter of twelve or fourteen hours at the most

DR HARRY GOLD There does not seem to be very much doubt that the actions of the vitamins may appear fairly quickly A bird that is unable to fly because of vitamin B<sub>1</sub> deficiency may be able to fly off within a few hours after a massive dose of vitamin B<sub>1</sub> A person with scurvy may after a massive dose of vitamin C, show unequivocal improvement within twenty-four hours This, also, applies to the case of defective dark adaptation, after a massive dose of vitamin A

If these patients are really suffering from a vitamin deficiency and receive adequate doses, considerable improvement might take place in the course of a few hours after administration

DR McKeen Cattell Dr Wolff, I think there is a certain amount of logic in the use of insulin and glucose, but I would like to point out that one could not expect too much from them I do not remember the exact figures now but approximately half of the total metabolism may result from the burning of alcohol It is apparent that that percentage cannot be increased very much without burning up the individual I think the actual increase in the elimination of alcohol by that procedure cannot be very important

DR WOLFF It could, perhaps have some other role than in total elimination. Could it have a specific effect in tissue?

Dr. CATTELL That might well be, as a matter of fact, it is known that life may be protected by such treatment The procedure possibly may be worth while in the treatment, and there is some evidence that the addition of glucose may im prove central nervous function, but I was thinking of the usual explanation that is given As far as promoting elimination is concerned. I believe that that cannot be accomplished to any important degree

DR WOLFF I would like to ask about subdigitalization in patients with delinum tremens Dr Gold, would you suppose, if a person were in danger of circulatory collapse as the result of this disorder, that it would make much difference whether he were getting subdigitalization doses. or full doses, or none at all?

DR. GOLD Unless there is fairly clear evidence of heart failure, I believe that digitalis would have no influence at all

Dr. Rennie The only death I have ever seen in a delinum tremens was due to cardiac failure DR Gold And not peripheral circulatory collapse?

DR RENNIE No, heart failure

Dr. Gold Of course, since there are about 13 000,000 cardiac patients in the United States and 2 500 000 people with alcoholic troubles, it would not be strange if coincidence produced a patient with both conditions from time to time I should think in the absence of heart disease, the problems of the heart in delirium tremens would not be those requiring digitalis

Dr. Wolff Would you suppose that alcohol would harm a heart that was not in failure or be-

ginning to fail?

Dr. Gold I doubt very much that it would in the range of concentrations in humans

Dr. Wolff If it did, would you suppose digr talis would make any difference?

DR GOLD I would doubt it.

Dr. Wolff Dr Rennie we see from time to time individuals who have been addicted to one form of a sedative or who take sedatives for con vulsions, who have fits precipitated by the sudden withdrawal of such a medicament. Apparently there is danger of fits in the alcoholic who sud dealy has his alcohol withheld (Dunning Inter national Clinic III vol 3, 1940) When you say that alcohol should be completely and suddenly withdrawn in chronic alcoholics, do you consider such a possibility? Is hydrotherapy and I assume you mean submersion in a tub for hours sufficient, or might the alcoholic in addition receive a bromide a barbiturate or some agent other than alcohol, or would you withdraw all medicaments during this precarious period?

DR RENYIE I would not withdraw all medica Routinely in a delirum tremens patient. when I remove alcohol I replace it with a sedative, preferably paraldehyde. Most alcoholics prefer it and it also seems to be about the most effective No I would not remove alcohol and leave that person with no support at all He is much too tremulous, anxious and frightened clearly needs sedation as well as prolonged baths This holds for the management of the chronic, the acute alcoholic, as well as the patient with delir

May I say something about the convulsive manifestation?

DR WOLLE Please do

lum tremens

Dr. Rennie There is a very rare condition associated with alcohol but more with the ingestion of it and not with the cessation of it and that is the condition which I designated as pathologic There are cerwith epileptoid manifestations tain individuals, probably epileptoid, who may not have convulsive scirures without alcohol but who show them after the long-continued use of I have never observed the production of a convulsion as the result of the withdrawal of alcohol as we do see convulsions following the immediate withdrawal of barbiturate medication \*

DR WOLFF You referred in your discussion of the management of delirium tremens to the use of sodium chloride and large amounts of fluid Is there not the impression—and perhaps I am wrong—that some of these people have "wet" brains?

DR RENNIE Dr Wolff is needling me because I wrote a manuscript recently in which I recom mended hypertonic glucose for the edema of the brain Dr Wolff, you could answer that question better than I can

DR Wolff Although postmortem edema in patients with delirium tremens has been considered to be present by Nazum and Le Count (J.A)M.A 67 1822 (1916)) I am personally not convinced that it makes much difference whether one gives more or less than the usual amount of fluid or salt Perhaps some of these people are pretty ' dry 'after hours without fluid or food and therefore are entitled to fluid for reasons of their dehy dration

Dr. Rennie Most of them are usually badly dehydrated

DR. Gold What i the fact in relation to hypertonic glucose solution? Does it seem to make them better or is it one of those practices continued by the momentum of tradition?

<sup>\*</sup> Since these comments, I have seen one lcoholic patient wh soffered a convolution during withdrawal. He had a normal electrocardi gram.

DR RENNIE Dr Bender, whom I have heard discuss alcoholism, has always used the so-called alcoholic wet brain, the edema of the dura and pia-arachnoid, as the paradigm of what alcohol does to the rest of the human body If one assumes that in delirium tremens there is intracranial edema, there is a rationale in attempting to reduce it by the use of a hypertonic solution You have also heard that Dr Wolff does not agree with that

DR WOLFF It does not matter whether I agree with it or not I don't believe it has been demonstrated I would also like to know whether there has been any evidence to the contrary

DR GOLD How do we now stand with regard to the precipitation of delirium tremens by the withdrawal of alcohol?

DR RENNIE It is my impression that more patients with delirium tremens are precipitated into it by the abrupt cessation of taking alcohol than those who develop it during the course of the continuous use of alcohol. One sees it occasionally on a surgical service after a patient who has not been recognized as an alcoholic has had an operation. Following the operation, with abrupt withdrawal of alcohol, one may get a delirious patient.

Nevertheless, we withdraw alcohol abruptly These are our reasons—If the patient already has delirium tremens there is no problem of inducing delirium. If the patient is a chronic alcoholic, but has not developed delirium tremens, we take the chance that he can, with adequate medication, avoid delirium. As I remember, some ten years ago in a large series, I think at Bellevie, or perhaps at one of the state hospitals, in several thousand cases alcohol was abruptly withdrawn, and, in another large group, the patients were tapered off. There seemed to be no significant difference in the incidence of delirious reactions in the two groups.

DR GOLD Wortis wrote a paper a few years ago on his experiences in Bellevue in that connection. He said there was nothing to the idea of precipitating delirium tremens by the abrupt withdrawal of alcohol. He used as evidence the experience there, in which it was found that very few cases of delirium tremens developed on the wards when the withdrawal was abrupt

DR WOLFF It is only fair to say that a certain number of people stop drinking as the first manifestation of their delirium tremens. This may confuse and cause some to believe that the withdrawal of the alcohol has caused the gastritis, restlessness, and anxiety. Would you care to comment on this point?

DR RENNIE I think that that is probably so There is a difference between abrupt self-withdrawal with no further support and abrupt withdrawal in the hospital with the support of sedation, hydrotherapy, and psychotherapy. The latter makes an appreciable difference in whether or not delirium develops

DR WALTER MODELL Dr Rennie, you expressed a fear that in alcoholics there was a danger of dependence on sedatives, on the barbiturates, and especially in the case of chloral hydrate

DR RENNIE I did not mean it was greater than in other addicts It is the tendency of alcoholics to lean on props

VISITOR I would like to ask Dr Rennie if he had any explanation of why the hallucinations of delirium tremens are so terrifying while hallucinations induced by other drugs may actually be amusing or pleasant

DR RENNIE They are not invariably terrifing in delirium tremens. I have seen patients in
delirium tremens who were vistly amused by the
parade of bugs across the wall. It need not be,
although most commonly there is a fear reaction
Why that is, I don't know. Do you, Dr Wolff?

DR Wolff I have examined 106 people with delirium from 27 different etiologic agents, and I could not see that the precipitating cause made much difference in the content of the delirium. It happens that delirium is commonly induced by or associated with the use of alcohol (in 30 of the 106 patients I studied). It also happens that many people are frightened when things become unreal.

They get shaky when they have visual hallucinations But there are some who can look with detachment upon such things, just as they can look at other deviant circumstances in their lives I think that the reaction depends on the temperament and experience of the patient, and is a highly individualized matter

DR GOLD I wonder if Dr Rennie would say something about that strange mixture which is used to produce vomiting. Why a mixture of pilocarpine and emetine? Why ephedrine should also be used I cannot understand. It seems to me there ought to be much simpler ways of producing sustained nausea. A few teaspoonfuls of syrup of ipecac will make people remain in a state of nausea for hours on end. Is there anything more to that mixture? Had the originators any thoughts in mind other than to produce nausea?

DR RENNIE I don't know

STUDENT I should like to know what Dr Rennie thinks of conditioned-reflex therapy?

DR RENNIE There is nothing very new about conditioned-reflex therapy In 1890 there was the Keely cure, which is comparable. The only new item is the use of the scientific term, conditioned-reflex. One might think of this procedure, producing a conditioned type of response, conditioned vomiting, because it occurred, previously, so regularly in association with the taste of alcohol. I have not used the method.

VISITOR Is the victim aware of what he is getting with each drink or is it just slipped in very quietly?

Dr. Rennie A friend of mine told me of a third person whom he met on his way to his doctor's office with a pint of gin in his pocket. "See this," he said, "I am going to get one ounce of it, and then I have to turn the bottle over to the doctor "

He had to bring his own alcohol for his treat He knew perfectly well what he was get The rationale of the treatment is made perfectly clear to these patients, and they are cooperative with the procedure

DR. CATTELL This treatment actually sets up conditioning so that they respond later to the alcohol alone, with vomiting?

DR RENVIE Right

Dr. Wolfr Would that work if a man did not wish to be helped?

Dr. Rennie I don't know of any therapy for alcoholies which will work against the wishes of the person to be helped

STUDENT Is it not likely that the alcoholic who uses alcohol for purposes of release will turn to something else if he is deprived of alcohol?

Dr. Revnie I am very glad you brought that up For that reason treatment must always be combined with active psychotherapeutic measures VISITOR Would you say something about the

incidence of suicide during the withdrawal in debrium tremens? DR RENNIE I have not heard that it was in

any souse a common occurrence Same Visitor Don't alcoholics, during with drawal, use the threat of suicide as sort of a drive

to get more whisky?

Dr. Rennie That has not been my experi

VISITOR Dr Rennie is it your impression that when things are worked out more ideally at some luture date that in the over all management of the patient some attention would be paid to the family of the alcoholic, not only to the wife of the married man but also to his parents?

Dr. Rennie I think that is extremely important A great deal of attention must be devoted to the family or the desperate human beings. They make anxious and They are anxious and the more the more they are worned They are apt to have the more common prevailing social attitude that this is a weakness a defect of character They are frequently either extremely overindulgent with the alcoholic or overly punitive. They are rarely able to accept this as a genuine illness, deserving of medical care. They need a great deal in the way of education and understanding not only as to what the problem is, but also what the steps in

the treatment should be Obviously, where they play a leading role in the psychogenesis of an alcoholic's problems, they must be drawn into the treatment Sometimes indeed they need help themselves, but there is a very large area in the whole psychotherapeutic problem in which the family plays a leading role and into which they must be drawn if treatment is to be effective. Dr. Wolff Dr Rennie, I know it is hopeless to try to make a prognostic statement. Cures seem to vary anywhere from 1 to 3 in 10 to 7 or 8 in 10 Does that depend on the type of patient selected or the type of therapy? What would you say the variables are?

DR. RENNIL The highest figure I know is about 85 per cent cures. That was in a group of patients who were not in a hospital but on a farm where they worked all day, contributed to the life of the group, and where they had only fellow alcoholic patients as companions.

Obviously, the percentage of cures depends on a number of factors What is the fundamental cause of the disorder? Is it a relatively reactive condition amenable to direct attack, or is it so deeply ingrained in the personality makeup of the individual that it requires a long devious intensive psychotherapeutic exploration? Does it occur as a symptom in a well-integrated, well organized successful individual with many assets to draw upon or does it occur in a so-called psychopathic personality unstable and undependable and lacking in rational goals? Personality makeup makes a tremendous difference The duration of disability makes a difference, as does the age of onset or age in which the condition reaches its All of these factors may affect prognosis. peak

The skill integrity and sincerity of the therapist make a still greater difference in prognosis The man who claimed the 85 per cent cures which I just mentioned is one who very early in his career of treating of alcoholics felt that he had to give up drinking himself that he could not hope to be sincere and to sell a patient the idea that a nondrinking life could be useful and constructive if he were having cocktails at dinner convinced that unless one is a nondrinker one can not be a good therapist of the alcoholic.

The Alcoholics Anonymous group rely very heavily upon an inspirational quality of therapy which is wo ren into a relimous consideration of the power of God in giving strength to these people. Something of the same kind of fervor marks the personality of a good therapist of an alcoholic.

Dr. Wolff The hour is up and we shall have to end our discussion.

#### Summary

Dr. Modera Alcoholism is still a vast un

solved therapeutic problem approximately 200,-000 persons in this country are disabled by it and more than ten times as many are affected to a It was brought out that most lesser degree physicians who treat alcoholics are not serious students of the problem, that there are few hospitals prepared to take care of alcoholics, and that there are only a few groups in this country who, like Alcoholics Anonymous, attempt to provide help for the treatment of all aspects of the broad problem

The cure of the chronic alcoholic requires the integration of the psychologic, medical, and social aspects of the patient's problems therapy is of outstanding importance proper psychiatric classification of the patients, whether he is a "steady" or a "spree" drinker, and the reasons for the drinking will determine psychotherapy

The alcoholic is best treated when removed to a hospital or other environment less stressful Alcohol is generally withdrawn than his own abruptly and without any "tapering off" Psychotherapy, sedation, assurance, and good nursing are substituted A novel approach to alcoholism called the conditioned-reflex or conditioned-aversion treatment, which has proved highly successful in some institutions, was discussed form of therapy the patient is given, together with an alcoholic drink, an injection of an emetic mix-This conditions the patient so that eventure tually he vomits from alcohol alone Regardless of the method used, however, unless the difficulties which drove the patient to become an alcoholic are corrected, and the patient is cooperative, the "cure" will be temporary, and the patient will return to alcohol or turn to some other form of escape

The medical treatment discussed concerned acute alcoholism and delirium tremens alcoholism about 25 units of insulin is given together with an infusion of one or two liters of 5 or 10 per cent glucose solution Although the purpose is to accelerate the rate of oxidation of alcohol in the liver, it was pointed out that, on a physiologic basis, this had only limited possibility in that direction, but that, on the other hand, the therapy might serve other useful purposes Special attention is paid to diet, and especially to vitamin supplementation Massive doses of many vitamins are often given Some feel that vitamin B fractions are of assistance in facilitating the metobolism of alcohol However, since these patients, usually, are poorly nourished and frequently suffer from clinical or subclinical vitamin deficiencies, this may serve as the basis for the rational use of vitamins The parenteral administration of saline is indicated in cases in which there has been considerable fluid loss, as after prolonged vomiting or diarrhea Intercurrent infections are watched for Pneumonia and circulatory collapse are the most common, serious com-A careful physical examination is necessary since, although alcohol may be detected on the patient's breath, his coma may be due to other causes such as fracture of the skull, diabetes, or uremia

Delirium tremens presents other problems is usually a self-limiting manifestation of alcoholism, lasting about five or six days ization and reassurance are indicated of the disorientation, serious accidents must be guarded against The treatment for acute alcoholism is followed Sedatives, most frequently paraldehyde, 10 to 20 cc by mouth, or smaller doses by muscle, may be necessary therapy is a most useful, nonchemical, sedative

The precipitation of delirium by the abrupt withdrawal of alcohol was discussed It was brought out that although this might precipitate delirium in occasional cases, it was not a serious contingency in the well-organized alcoholic ward, in which the patient is not left without support and sedation, and where psychotherapy is applied simultaneously with the withdrawal of the alcohol

## DR REULING WILL HEAD TUBERCULOSIS ASSOCIATION

Dr James R Reuling, director of medicine of Flushing Hospital and Queens General Hospital, New York City, was named president of the National Tuberculosis Association at the Association's annual meeting in June He succeeds Dr William Shepard, of San Francisco

A member of the N T.A. board of directors since 1940, Dr Reuling is treasurer of the Medical So-

ciety of the State of New York, a member of the American Medical Association and the American Trudeau Society, and a fellow of the American College of Physicians He formerly was president and chairman of the board of trustees of the Queens County Medical Society and president of the Queensboro Tuberculosis and Health Association

#### NECROLOGY

Albert F Barry, M.D., 79, of Amityville, died on December 12 1046 A graduate of New York University College of Medicine, in 1888 Dr Barry was resident physician at Brunswick House in

Amityville

Michael Block, M.D., 73 of New York City died in June. Dr Block was a graduate of the Medical College of Virginia in 1900 He was assistant physician at the Good Samaritan Hospital and a member of the American Medical Association and the New York State and County medical societies

Norbert Odeon Bourque, M.D 69 of Now York City died on November 23 1940 He was a member of the American Medical Association and New York State and County medical societies. A graduate of the University of Tennessee Medical College in 1906 Dr Bourque also was graduated from the University of Lausanne in Switzerland in 1923 and the University of Paris in 1925 He was a member of the staff of the Mother Cabrini Memorial Hos-

pital in Chicago, Illinois
Dayre B De Waitoff, M.D., of Brooklyn, died on
June 19 Ho was 87 years old Born in Russia Dr
De Waltoff, was graduated from St. Vladimir's Medical College in 1887 and later from the Long

Island College of Medicine.

William Donovan, M.D., 78, of New York City died on January 30 He was a graduate of Bellevue Medical College in 1898 and an alumnus of City Hospital. He was a member of the American Medical Association and the New York State and

County medical societies

Martin Downey M.D. 80, of New York City, diod on November 4 1948 He was a graduate of Bellevue Hospital Medical College in 1893 He was a member of the New York Academy of Medicine the American Medical Association, and the New York State and County medical societies

L. B Gardner, M.D., 73, of Geneva, died on September I, 1946 He was graduated from Eclectic Medical College, in Cincinnati in 1899 A member of the American Medical Association, the New York State and Ontario County medical societies he was on the staff of the Geneva General Hospital

John Russel Foshay, M.D., of Peckakill, died on June 14, at the age of 67 He was graduated from the College of Physicians and Surgeons, Columbia University in 1909 and interned at French Hospital, New York. Until his retirement in 1946 Dr. Foshsy practiced medicine and surgery in Peckskill for thirty five years He had been president and sceretary of the medical board of Peckskill Hospital and was a member of the hospital a board of directors. He was a member of the American Medical Association, and the New York State and Westchester County medical societies

Ralph William Hall, M.D., 63 of Brooklyn formerly of East Chatham died on September 7, 1948 He was graduated from the Long Island

College of Medicine in 1911

Edward L. Hanes, M.D., of Altadena, California, and formerly of Rochester died June 14 at the age of 76 A neuropsychiatrist Dr. Hanes was graduated from Albany Medical College in 1899 and served the latest the control of the contro his internship at the Lying In Hospital in New York In 1909 he began private practice in Roches ter, serving also as neurologist at General, St. Mary s, and Genesee hospitals in Rochester He had charge of the neuropsychiatric division of

Base Hospital 19 overseas in the first World War and later was a consultant to the Veterans Administration He was also on the staffs of Craig Colony at Sonyea, the Hudson River State Hospital in Poughkeepsie, and the Rochester State Hospital

Dr Hanes was a founder of the Rochester Mental Hygiene Society and the author of several books He was a member of the American Medical Associa tion, the American Psychiatric Association, the Rochester Academy of Medicine and the New York State and Monroe County medical soleties Waiter Gotthard Hirsemann, M.D., 88 of Central

Valley died on May 26 He was a graduate of the Long Island College of Medicine in 1903 and interned at Norwegian Hospital, Brooklyn. Dr Hirsemann was assistant attending physician at Cornwall Hospital, in Cornwall. He was a member of the American Medical Association, the State Medical Society and Orange County Medical Society

Edward Katlan M.D. 36 of the Bronx died in June He was graduated from Lausanne University of Medicine in Switzerland in 1938. He was clinical assistant in dermatology at Morrisania Hospital and clinical assistant at Lebanon Hospital both in the

Dr Katlan was a member of the Bronx County Medical Society the State Medical Society and the

American Medical Association

George Ludwig Laporte, M.D., of New York City, died on June 16 at the age of 73 A graduate of the College of Physicians and Surgoons Columbia University in 1864 he was a general practitioner of medicine in New York City for the past fifty years He was consultant to the Lenox Hill Hospital where he had served as an intern. He was a mem ber of the New York Academy of Medicine, the New York State and County medical societies, and the American Medical Association

Mortimer Lippmann, M.D., 53, of Queens Village, died on December 10, 1946 He was graduated from the Long Island College of Medicine in 1920 He was a member of the Medical Society of the

bate of New York, the Lings County Medical Society and the American Medical Association Washington Merscher M.D., of Clifton Springs died on June 15 at the age of 57 He was a member of the staff of Clifton Springs Sanitarium for the past six years. A graduate of the University of Pennsylvania Medical College Dr Merscher was a member of the American Medical Association, and the New York State and Ontario County medical societies

Harold Arthur Morris M D 62 of Brooklyn, died on January 17 He was a graduate of the Long Island College of Medicino in 1907 and a Fellow of the American College of Surgeons. Dr Morris was attending surgeon at Swedish Hospital in Brooklyn, and consulting surgeon at Harlem Valley btate Hospital in Wingdale He was a member of the American Medical Association, New York State and Kings County medical societies and the Flatbush Medical Society

Clay Ray Murray, M.D. of New York City died on June 14 at the age of 56 He was attending orthopedic surgeon and director of the fracture service of Presbyterian Hospital and Vanderbilt Clinic in New York City since 1945 He was also professor of orthopedic surgery of the College of

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Physicians and Surgeons, Columbia University, from which he received his medical degree in 1912 After interning at New York Hospital, he became assistant surgeon there and at Fordham Hospital in 1916, but left for service with the Army Medical Corps in 1917 He was retired for disability in the

line of duty in 1921

Dr Murray has been an associate attending surgeon at New York Hospital, Polyclinic Hospital, Flower and Fifth Avenue Hospital, Presbyterian Hospital, and Vanderbilt Clinic He also was a consultant in the department of traumatic surgery and fractures of General Hospital, Hackensack, New Jersey, a consultant at the Sharon, Connecticut, Hospital, a consultant in orthopedics at St. Joseph's Hospital, Far Rockaway, Long Island, and an honorary consulting orthopedic surgeon of Harlem Hospital

Since 1923 Dr Murray has been an instructor and professor of surgery at the College of Physicians and Surgeons, Columbia University, and since 1945, professor of orthopedic surgery. He is the author of several books on surgery and fractures

Dr Murray was a member of the Medical Board of Presbyterian Hospital, the American Board of Surgery, the American Board of Orthopedic Surgery, the American Association for the Advancement of Science, the New York Surgical Society, the Surgical Research Club, the Harvey Society, the Southern Medical Society, the New York State and County medical societies, and the advisory committee of the State Commissioner of Health on Crippled Children He was a fellow of the American Surgical Association, the American College of Surgeons, the American Academy of Orthopedic Surgeons, and the American Association for the Surgery of Trauma

Marcus Neustaedter, M D, 76, of New York City, died on June 17 Since 1925 he had been consulting neurologist of the New York Cancer Institute A native of Austria, Dr Neustaedter was graduated from the Bellevue Hospital Medical College in 1896, and ten years later received the degree of doctor of philosophy at New York Uni-

versity

He formerly was chief neurologist at Kings County and St Mary's hospitals, clinical professor of neurology at the New York Polyclinic Medical School and Hospital, instructor, lecturer, and clinical neurologist at Bellevue and University hospitals, and neurologist at the outpatient department at Bellevue Hospital From 1925 to 1935 he was neurological director of the medical board of the Central Neurological Hospital on Welfare Island

Dr Neustaedter was an authority on poliomyelitis and lethargic encephalitis and was the author

of numerous papers on these diseases

He was a member of the American Medical Association, the New York State and County medical societies, the New York Academy of Medicine, the Society for Research in Neurology, and the New York Neurological Society

Frederick Scoville Nicoll, M.D., 40, of Brooklyn, died on December 30, 1946 He was a graduate of Cornell University Medical College in the class of 1935 He was a member of the staff of Peninsula

General Hospital, Salisbury, Maryland

Francis Jeremiah O'Brien, MD, of Rochester, died on December 6, 1946, at the age of 74 A graduate of the College of Physicians and Surgeons, Columbia University, in 1899, he served in the Army Medical Corps during World War I He was on the staff of St Mary's Hospital in Rochester

James Tresilian Padgett, M D, 71, of New York City, died on June 10 After graduating from the University of Kansas City Medical College in 1900, and from the Louisville Medical College in 1904, Dr Padgett was surgeon for the Union Pacific Railroad at Ellis, Kansas, until he moved to New York in 1907 For some years, until his retirement in 1944, he was in charge of the gynecology department of the Lutheran Hospital In 1928 he received a degree from the University of Vienna

Dr Padgett was a member of the American Medical Association, and the New York State and County

medical societies

Mark Seth Reuben, MD, of New York City, died January 15 at the age of 63 A graduate of the College of Physicians and Surgeons, Columbia University, in 1906, he was associate in pediatrics at Beth Israel Hospital Dr Reubens was formerly assistant and associate in pediatrics at the College of Physicians and Surgeons and chief of clinic, pediatric department of Vanderbilt Clinic He was a member of the New York Academy of Medicine

a member of the New York Academy of Medicine Aaron Rokeach, M D, 70, of Brooklyn, died on December 6, 1946 He was a graduate of the College of Physicians and Surgeons, Columbia Uni

versity, in 1903

Morris Rosenbaum, M D, 66, of New York City, died on February 1 He was a graduate of the College of Physicians and Surgeons, Columbia University, in 1903 Dr Rosenbaum was formerly chief ophthalmologist at Stuyvesant Polyclinic Hospital, assistant in ophthalmologic surgery at the New York Eye and Ear Infirmary, and senior clinical assistant in ophthalmology at Mt Sinsi Hospital

Alfred Scheyer, M.D., of New York City, died on March 17 He was graduated from the University of Berlin in 1897 and was formerly on the staffs of the Wickersham and Wadsworth hospitals

John Joseph Sheehey, M.D., of Garrison, died on October 2, 1946 He was 79 years of age Dr. Sheehey was a graduate of the University of Wooster, Cleveland, Ohio, in 1891 He served on the staffs of the Coney Island, Samaritan, Harbor, and Caledonia hospitals in Brooklyn, later retiring to the Franciscan Monastery to serve as physician for the Friars Dr. Sheehey was a member of the American Medical Association, the New York State and Kings County medical societies, and the Academy of Medicine

Frederick Edward Sperry, M D, 60, of Buffalo, died on December 6, 1946 He was a graduate of the University of Buffalo, School of Medicine, in 1910, and was on the courtesy staff of the Millard Fillmore Hospital in Buffalo Dr Sperry was a member of the American Medical Association, and the Eric County and New York State medical

societies

Alice Adele Squire, M.D., of Brooklyn, died on October 4, 1946, at the age of 69 She was a graduate of the New York Medical College for Women, in 1901 She was a member of the American Medical Association, and the Kings County and the

New York State medical societies

Edward Augustine Stapleton, M D, of Albany, died on June 11 He was 67 years old He was graduated from Albany Medical College in 1904 and from the University of Vienna For the last thirty-five years Dr Stapleton had been practicing medicine in Albany as an eye, ear, nose, and throat specialist He was a member of the Albany County and New York State medical societies, the Eastern New York Eye, Ear, Nose, and Throat Society, and the American Medical Association

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## House of Delegates Minutes of the Annual Meeting May 5 to May 7, 1947

THE 141st Annual Meeting of the House of Delegates of the Medical Society of the State of New York was held at the Memorial Auditorium, Buffalo New York, on Monday, May 8 1947, at 10 10 A.M. Dr Albert F R. Andresen Speaker, Dr Walter P. Anderton Secretary Dr W Guernsoy Frey, Jr Assistant Secretary
SPEAKER ANDRESS The House will please come

to order

I will ask the Secretary for a report from the

Reference Committee on Credentials.

Schetary Anderton Mr Speaker there are no disputed delegations I am informed by the Chair man of the Reference Committee on Credentials and all on our rolls are entitled to vote.

SPEAKER ANDRESEN The Speaker declares the 141st Session of the House of Delegates open for the

transaction of business.

#### Section 1

#### Report of Reference Committee on Credentials

SPEAKER ANDRESEN We will now hear from the Chairman of the Credentials Committee McCarty

SECRETARY ANDERTON He is out at the desk, but

a quorum is present, sır The Secretary reports that SPEAKER ANDRESEN a quorum is present. Sixty members constitute a quorum, so that we are ready for business.

#### Section 2

#### Opening Remarks of the Speaker

SPEAKER ANDRESEN It is with a feeling of sadness that I appear before you this morning as your Speaker When you elected me your Vice-Speaker last year I expected to sit here at the side of the Speaker my friend, Dr Sullivan, and learn from him the job of conducting this meeting, in the expecta-tion that perhaps some day I might become the Speaker but this happy genial friend of every mem-ber of this House, this indefatigable worker for the best interests of our profession this fine surgeon who should have had before him many years of service to humanity has been taken from our midst. We mourn his passing we are grateful that he was amongst us. I ask you to rise and spend a minute in selent meditation in memory of our friend, Frank Leslie Sullivan and in consideration of the responsibility be passed on to us to further the interests of

the medical profession of the State of New York.

The members arose and stood with bowed heads in silent memory of their departed colleague,

Dr Frank Lealle Sullivan

SPEAKER ANDRESEN I hope that the members of this House will have patience with me as a neo-phyte in this job of Speaker especially as my prede-cessor Dr. Louis H. Bauer generally recognized as perhaps the most brilliant presiding officer in the medical profession who hold this office for six years, set a precedent which would be difficult for anyone to follow I have not been a delegate long enough to know you all by name, and this fact, combined with my notorious lack of memory for names, will make it necessary for me to ask each member dear ing to speak to mention his name and the county he

represents. This will avoid embarrassment to the member and to me. To expedite business I also request that anyone wishing to make a motion or to address the House should come up to the rostrum and speak distinctly into the microphone and to speak briefly and to the point. It is a rule of this House that except under extraordinary circumstances and then only by the consent of a majority vote of the House no one may be allowed to speak for longer than five minutes nor more than once on any subject. It is the violation of this rule which so often delays proceedings and prevents our hear ing the opinions of others who do not enter into a discussion in order not to take up unnecessary time.

I expect to enforce this rule

As a delegate to this House and to the House of Delegates of the American Medical Association I have often been impressed with their resemblance to our legislative bodies, in Albany and in Washington While we here represent only the medical profession and the legislative bodies represent the entire population, our methods of procedure are similar tions made on the floor and reports of officers and standing committees are referred to reference committees whose recommendations are acted upon by the House as a whole The same rules of order are applied, and the business of both houses is often delayed by garrulous speakers, yet how different is the spirit displayed by the members. In Congress unfortunately for the good of our Country as a whole, too many congressmen think more about their re-election than about their responsibility to the Nation, spend more time seeking to get appropria-tions and favors for their local constituency or for pressure groups than to enact legislation of benefit to the Country and to the world at large I have been pleased to observe that in our medical assemblies no such localism no such deare for self-aggrandise-ment, no such abject surrender to special interests has been noticeable. When our delegates make motions their purpose practically always is altruistic and while of necessity the business of the House will concern matters of importance to the preservation and betterment of medical practice and of the status of the individual practitioner in the end all improvements in medical practice must accrue to the benefit of the public whose health and happiness are so largely dependent upon the type of medical care provided for it.

Members of the House, I am proud to be your presiding officer—I shall do my best to act as your umpire at this meeting and unlike the umpires at Ebbet's Field in my county I am protected by the fact that the management of this House has for bidden the sale of soda pop among the spectators.

#### Section 3

#### Approval of the Minutes of the 1946 Session

SPEAKER ANDRESEN The first order of business is the approval of the minutes of the 1916 Session. SECRETARY ANDERTON I move that the reading of the minutes be dispensed with, and that they be approved as published in the July 1 1946, July 15 1046, and August 1, 1946 issues of the New York STATE JOHNAL OF MEDICINE.

Dr. Clarence G Bandler, New York I second that motion

There being no discussion, the motion was put to a vote, and was unanimously carried

(Sec 51) Section 4 Reference Committees

SPEAKER ANDRESEN Will the Secretary read the

Reference Committee appointments?

SECRETARY ANDERTON The Reference Committees for the 1947 House of Delegates are as fol-

REFERENCE COMMITTEE ON CREDENTIALS

Charles F McCarty Chairman Kings County Alfred K Bates Cayuna County Victor W Bergstrom, Broome County Goodlatte B Gilmore Bronx County George H Burgin Herkimer County

REFERENCE COMMITTEE ON REPORT OF PRESIDENT

Philip D Allen, Chairman New York County Leo F Schiff Clinton County Harry Golembe, Sullivan County William Klein Bronx County Francis G Riley Queens County

REFERENCE COMMITTLE ON REPORTS OF SECRETARY (also Supplementary) CENSORS AND DISTRICT BRANCHES

Elton R Dickson Chairman Broome County Wendell R Ames Cattaraugus County Raymond F Kircher Alban, County Charles A Anderson Kings County Frederick S Wetherell Onondaga County

REFERENCE COMMITTEE ON REPORTS OF TREASURER TRUSTEES (also Supplementary) AND FINANCE COMMITTEE

John D Naples Chairman Eric County
Irwin E Siris Kings County
John J Fingan Monroe County
Homer J Knickerbocker Ontario County
William C White New York County

REFERENCE COMMITTEE ON REPORT OF PLANNING COMMITTEE FOR MEDICAL POLICIES

Thomas J D Angelo Chairman Queens County
Edward C Veprovsky Queens County
E C Foster, lates County
Harry E Reynolds (Section Delegate) Schenectady
County
William J Tracy Steuben County

REFERENCE COMMITTEE ON REPORTS OF MALPRACTICE INSURANCE AND DEFENSE BOARD AND LEGAL COUNSEL

Roy B Henline New York County
Roy B Henline New York County
William A Moulton, Tioga County
Charles C Trembley Franklin County
Harold F R Brown Eric County

REFERENCE COMMITTEE ON CONSTITUTION AND BY LAWS AMENDMENTS

Peter J Di Natale Charman Genesee County Ezra A Wolff Queens County Joseph L kiley Saratoga County W W Street Onondaga County Sylvester C Clemans Fulton County

REFERENCE COMMITTEE ON REPORT OF COUNCIL—PART I Postgraduate Education (also Supplementary)

Charles F Rourke Chairman Schenbetady County Scott Lord Smith District Branch Paul F Willwerth Schuyler County Donald E McKenna Kings County Kenneth T Bott Greene County

REFERENCE COMMITTEE ON REPORT OF COUNCIL—PART II
Maternal and Child Welfare (also Supplementary)

Samuel Burk Chairman New York County T A Lynch, Lewis County E Kenneth Horton Nasau County Edgar Bleber, Chautauqua County William A Peart Niagara County

REFERENCE COMMITTEE ON REPORT OF COUNCIL—PART III School and Industrial Health

John T Donovan Chairman Eric County Theodore R Proper Orange County Mahlon C Halleck Otsego County Vincent Juster Queens County Leo S Drevler Kings County

REFERENCE COMMITTEE ON REPORT OF COUNCIL—PART IV Public Health Activities Cancer

Cancer
Hard of Hearing and the Deaf
Mental Hygiene (also Supplementary)
County Health Departments
Homologous Serum Jaundice
BCG Immunization (also Supplementary)

Abraham Koplowitz Chairman Kings County
Donald Malven Dutchess County
Everett C Jessup District Branch
W T Boland, Chemung County
A H Aaron Eric County

REFERENCE COMMITTEE ON REPORT OF COUNCIL—PART V

Rehabilitation Rehabilitation
Rural Medical Service
A N Selman Chairman Rockland County
Stanley B Folts Seneca County
E L Harmon Westchester County
M C L McGuinness New York County
John L Sengstack Suffolk County

REFERENCE COMMITTEE ON REPORT OF
COUNCIL—PART VI
Public Relations and Economics
Public Medical Care
Woman Medical Student and Intern
Medical Service and Public Relations
Joint Committee of the New York State Hospital Association and The Medical Society of the State of New York

Edward P Flood Chairman Bronx County Goodwin A Distler Queens County Stephen II Curtis Section Delegate Charles A Prudhon Jefferson County Porter A Steele Ene County

REFERENCE COMMITTEE ON REPORT OF COUNCIL—PART VII
Medical Care Insurance (also Supplementary)

Denver M Vickers Chairman, Washington County John E Wattenburg Cortland County Leo S Schwartz Kings County John M Galbraith Nassau County A Wilbur Duryce New York County

REFERENCE COMMITTEE ON REPORT OF COUNCIL—PART VIII
Veterans Affairs
Liaison with Veterans Administration

Leo E Gibson Chairman Onondaga County John L O Brinn Bronx County Benjamin M Bernstein Kings County Nelson W Strohm Eric County Joseph P Henry Monroe County

REFERENCE COMMITTEE ON REPORT OF COUNCIL—PART IX

Legislation (also Supplementary) Andrew A Eggston Charman Westchester County Thurman B Givan Kings County Wm B Rawis New York County John L Edwards Columbia County Felix Ottaviano Madison County

REFERENCE COMMITTEE ON REPORT OF COUNCIL—PART X
Workmen s Compensation (also Supplementary)

F W Holcomb, Chairman Ulster County Joseph H Diamond Richmond County Olin J Mowry Oswego County Arthur J Fischl, Queens County Ralph Sheldon Wayne County

REFERENCE COMMITTEE ON REPORT OF COUNCIL—PART \I Publication

Medical Publicity Contract with Kings County Medical Society Eugene H Coon Chairman Nassau County Frank LaGattuta Bronx County Ivan Peterson District Branch Charles S Lakeman Monroe County Irving Sanda Kings County

REFERENCE COMMITTEE ON REPORT OF COUNCIL—PART VII: Miscellaneous

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Modical Liconsurs
Nursing (also Supplementary)
Woman's Auxiliary
Office Administration and Policies Memorials (also Supplementary) Joseph Gols, Chairman, Essex County Donald D Prentice Albany County Burrill B Crohn, New York County John J Galpay, Kings County J M. Crumb Chenango County

REFERENCE COMMITTEE ON NEW BUSINESS A:

Leo F Simpson, Chairman, Monroe County John Dugan Orients County John F Kelley Oneida County Richard P Doody, Rensectaer County Joseph Tenopyr Mings County

REFERENCE COMMITTEE ON NEW BUSINESS B:

Frederick Williams, Chairman Bronx County Joseph II. Cornell Bohenectady County Harold B Davidson, New York County Morris Masion, Warres County Thomas M. Brennen Hings County

REFERENCE COMMITTEE ON NEW BUSINESS C: Theodore J. Curphey Chairman, Nessau County J. Lewis Amster Bronx County Norman E. Moore, Tompulus County Clarence G. Bandler New York County George C. Adle Westlebester County

SPEAKER ANDRESEN You have heard the list of Reference Committees and their Chairmon It is customary for those Committees to meet either immediately after this session, which I hope will be around half past twelve or one o clock or at some later time in the afternoon We ask that the Chairmen let Miss Dougherty know when they are going to moet so the list can be posted. We are going to have a list of the Committees, with their Chairmen and it is going to be posted by the door, with the time and place of their meeting noted thereon. I think it would be a very fine thing if anybody who is interested in any of the subjects that are brought up today or in any of the reports will go across the hall to the meeting of the appropriate reference com mittee and first fight out there what he has to say, so we will not have to take up so much time here tomorrow on the floor Very often motions that are made here on the floor amending committee reports could just as well have been raised and straightened out over in the reference committee meeting, and could have been disposed of there without taking

extra time to do so on the floor of the House We also would like the officers and council committee members who are concerned with any of the reports to hold themselves in readiness to come over and explain anything that they have written to the

reference committees.

We have heard from a few of the reference committees who are going to meet immediately after the

others are going to meet.

SECRETARY ANDERTON Mr Speaker, I move that the Reports and Supplementary Reports of Officers, Council Trustees and District Branches that have been published and distributed to the members of the llouse be referred to the respective reference

onunities without reading.

The motion was seconded by several
Da. Francisca W WILLIAMS, Bronz. On that
motion, the Bronx County Medical Society has directed me as one of its delegates in the discussion
of this motion, the country by the countr of this perennial motion by the Secretary to call the attention of all of the delegates to certain features of these reports, which Bronx County considers of

vital importance and worthy of deliberate consideration by each and every delegate during this 808810D

In the report of the Finance Committee a 1 recommendation to raise the dues is contemplated as a rider to the financing of our War Memorial

In the report of the Legislative Committee we were committed to the support of the Clancy Bill which specifically in the report of our Legis-lative Committee permits dentists and podiatrists to diagnose x rays of any part of the body

3 In the report of the Trustees, we wish to point

out it was necessary for us to pay for the audit of the Group Malpraetice Insurance Plan which the

House directed be made last year

4 Finally in regard to the report of the Mal practice Defense and Insurance Board and the resolution acted upon by this House at its last session I have been instructed to move an amendment to the motion of our Secretary that the report be read in full so as to inform all of the delegates and the mem bers of the Reference Committee that we may act intelligently tomorrow when the report comes before

In compliance with this specific instruction I so move you, Mr Speaker

SPEAKER ANDRESEN That will have to be an amendment to the motion already on the floor

Dr. WILLIAMS I am satusfied that it go through as an amendment

SECRETARY ANDERTON Does that contemplate

the reading of all the reports?

Dr. Williams No merely that of the Malpractice Defense and Insurance Board.

DR. THOUAS McCARTHY Bronz I would like to

second that amendment and then to speak on it.
Speaker Andresen The Chair rules that according to our regulations we are to refer any reports to Reference Committees and the discussions are to take place first in the reference committees and also if necessary are to take place on the floor when the reference committee is giving its report Therefore I consider that this particular amend ment is not in order

DR. WILLIAMS All I have done is to amend the motion that the Secretary made that we refer these reports and supplementary reports to the Reference Committees without reading. I have brought to the attention of the delegates several points that the Bronx County considers vitally important and also asked that one report be read Wo feel it is of such importance that every member of the House should be informed as to the details of it. That is all we aak in our amendment.

SPEAKER ANDRESEN May I also say that the Report of the Malpractice Insurance and Defense Board is going to be given in full later on this morning in the executive session. Will that satisfy you if that is given in full then?

DR. WILLIAMS It is going to be read before the

entire House?

SPEAKER ANDRESEN Yes.

DR. WILLIAMS Then that is satisfactory DR. J. STANLET KENNEY (Councilor) It is not

the intent to read the report in full at that executive session because the report has been circulated to every delegate. Each delegate has a copy of it. I have no objection to having it read in full, and am perfectly willing to have it done if the House so wishes, but I just wanted to clarify the situation that at the executive session it was not the intention to read the report

SPEAKER ANDRESEN Those reports have been distributed.

DR McCarthy Point of order I asked for the

floor to speak on the amendment SPEAKER ANDRESEN The report has been dis-SPEAKER ANDRESEN I don't know why we should have all of this discussion about reading it Everybody here, I hope, can read for himself the reports that have been distributed

DR WILLIAMS Can you assure me that every delegate here has read it?

SPEAKER ANDRESEN I don't know whether they have read it or not, but they are supposed to have read it

Dr. Williams That is what we would like to be sure of, Mr Speaker, that they are cognizant of what is actually contained in that particular report

DR THOMAS M D'ANGELO, Queens If the reports have been distributed we have done what we could for each individual delegate to bring them to their notice I don't see how this House can force each delegate to read the reports that have been distributed to him We carry out our duty and obligation when we see that each delegate gets a copy, and then it is up to him to read it. I have no objection to the report being read aloud now, but I think it is going to be a waste of time

Dr. McCarthy May I have the floor on this

amendment now?

Speaker Andresen Yes

DR McCarthy This amendment has been presented by Dr Williams, for the Bronx delegation, for several reasons This is the initial report of a Board created by the House of Delegates in 1946 We feel that the report is an excellent one, and that the distinguished and able members of this Board deserve our thanks They have been diligent, and they have produced something that is informative and comprehensive The reading of this report would be a fitting tribute to the Chairman of the Board, Dr J Stanley Kenney In the direction of this Board, as in his efforts with the preceding committee, Dr Kenney has labored long and earnestly He has never spared himself in his endeavor to serve this Society, and we feel that he deserves well of the Medical Society of the State of New York Read ing this report would, we feel, emphasize to the House of Delegates that in the possibly perilous years ahead for organized medicine loyalty of the membership based upon free and open information would be a stronger bulwark than that which is unenlightened and dissatisfied The Bronx delegation feels that the report is progress in the right direction

DR JOHN J MASTERSON (Trustee) In order to clarify the situation I would suggest that the Speaker request Dr Kenney to read the report in its entirety when the House goes into executive session later in the morning. Everybody has received a later in the morning Everybody has received a copy of the report, but I dare say many of the delegates have not read it. It is an important document, and I think it would refresh our memory if we

all heard it again

Speaker Andresen Is there any further discussion? If not, we will put the amendment to a vote that the report of the Malpractice Defense and Insurance Board be read in its entirety at the pres-

Dr. Joseph A Geis, Essex Those of us who have not read that report have the whole afternoon to Why take up the time of this body to read it over do that

The question on the amendment was called, and the amendment was put to a vote, and was

SPEAKER ANDRESEN Is there any further discussion on the motion to refer the reports and supplementary reports to the reference committees without

reading them in this House?

The question was called, and the motion was put to a vote, and was carried

Section 5 (See 92)

#### Supplementary to the Report of the Secretary

To the House of Delegates—Gentlemen

In conformance with a request from the Board of Regents of the University of the State of New York. the Council submitted the names of six members as nominees for two vacancies on the Medical Grievance Committee of the New York State Education Department The Board of Regents has recently appointed to membership on this Committee Dr William Walter Street, of Syracuse, and Dr Clarence Proctor Thomas, of Rochester

Respectfully submitted, W P ANDERTON, M D, Secretary

Section 6 (See 123)

#### Supplementary Report of the Board of Trustees

To the House of Delegates—Gentlemen

It is recommended that the House of Delegates direct

That a business survey be made of the greatly extended activities of the Society during the past eight years by a competent firm or other qualified persons, such firm-or persons to be chosen by the Council or a Committee thereof, appointed by the President of the Society, subject to the approval of the Board of Trustees, and under the direction of the Council, in order that the efficiency of the Society be increased, the relationship of expenditures of various departments to the over-all efficiency of the Society be evaluated, and such changes be made in the administration of the affairs of the Society by the Council upon the recommendations made in the report submitted after survey, subject to the approval of the Board of Trustees, as to the entailed expenditures only

That a new Committee of the Council be created entitled the Committee on Committees, to be composed of the Chairman of each of the Council Committees, the President, the President-Elect, the Past-President, and two additional members to be appointed by the President with the approval of the Council This Committee would act to coordinate all of the functions of the Council Committees so that unnecessary overlapping of functions would be diminished, integration of all of the work of the So-

ciety be made more efficient, and unnecessary expenditures be lessened

It is further recommended that careful consideration be given by the House to the fact that in the very near future the activities of the Society, limited as they must be by our dues income, must of necessity be diminished or the annual assessment of the members increased The Board desires to bring to the attention of the House the fact that the per capita dues of this Society are the lowest of those of any of the other State Societies of the United States comparable to the total State population or the total A list of the number of members of these Societies dues of the various State Societies will be furnished the House in the Report of a Committee of the Council

> Respectfully submitted, JAMES F ROONEY, M D, Chairman ALBERT A GARTNER WILLIAM H ROSS JOHN J MASTERSON EDWARD R. CUNNIFFE

Section 7 (See 72)

Annual Report—Planning Committee for Medical Policies-1947

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(1) In relation to hospital service regions and districts and population
(2) Bed Ratios

#### To the House of Delegates-Gentlemen

The Planning Committee for Medical Policies has completed its fourth year of study and analysis of policies concerning medical practice. In this report particular emphasis is placed on those topics related to government in medicine.

1 Organization —The organization of the Com

mittee has been the same as in previous years Since the last meeting of the House of Delegates in May, 1946 in New York City the following gentle-

men have made up the personnel of the Committee

J Stanley Konney, M D Chairman, New York
William Hale, M D (deceased) Utica
Louis H Bauer M D, Hempstead
F Leslie Sullivan M D (deceased) Schenectady
A. A. Gartner, M D Buffalo
Walter P, Anderton M D, Now York
Leo F Simpson M D, Rochester
Norman S Moore, M D, Ithaca
Walter W Mott M D White Plains
O W H Wilchell M D, Syrgense O W H. Mitchell, M D Syracuse Peter J Di Natale M D Batavia

Invitations to the meetings were extended to Laurance D Redway M D, Literary Editor of the Journal Robert Hannon M D Executive Officer of the Society, Mr Dwight Anderson, Executive Secretary, Daniel Mellen M.D. Chairman of the Committee on Rural Medicine Joseph S Lawrence M.D., Director of the Washington office Council on Medical Service of the American Medical Asso-These gentlemen have honored us with their presence and their contributions to our de-liberations have been wise and constructive. The Committee is appreciative and hereby acknowledges its thanks to them.

In the proper place during this 1947 meeting of the House of Delegates appropriate tribute will be paid to those officers and members of the House whom God in His wisdom has seen fit to take from our midst. At this time we pause to record a reverent expression of our esteem and regard for the two members of this Committee who have passed to their Eternal Reward-our late President, Dr William Hale, and the late Speaker of the House Dr F

Leslie Sullivan. These colleagues served our Committee with distinction and wisdom. They are sorely missed and the memories of their genial per sonalities will live always in the hearts and minds of those of us whose privilege it was to know them and work with them Dr Bauer sponsor of this Committee who has been a member since its beginning, now serves in his capacity as President of our State Society and we welcome Dr Albert F R. Andresen, who, as the new Speaker of the House new becomes a valued member of this Committee

2 Overlapping Duties of Council Committees — On September 12 1946 the Council referred to the Planning Committee for study and recommendation the following excerpt from the minutes of the meeting of the 1946 House of Delegates of the Medical

Society of the State of New York

The overlapping suggested by the President in the work of the necessarily complicated system of committees of the Society has not been demonstrated to your Reference Committee but if In the opinion of the Council, such duplication of function does exist we recommend the creation of a special Council committee to study the matter and formulate such amendments to the Constitution and Bylaws as will remedy the situation.

Your Planning Committee has given these in structions from the Council careful study month the Council agenda carried the listing of thirty-seven committees and subcommittees some of which report regularly from month to month and some very infrequently or not at all. Study showed that much overlapping and duplication of effort was apparent and a streamlining of these many commit tees in the interest of efficiency and to expedite the already heavy work of the Council seemed neces-In the process of reorganization some committees have been dropped entirely others transferred to already existing standing committees and in three instances, the titles have been changed to bring them in conformity with existing and compar able American Medical Association Committees and with the work they are performing in the administrative set-up of our Society

We would recommend the following changes and adjustments

That the National Casualty and Indemnity Insurance Committee be discontinued

That the Committee on Revising Principles of Professional Conduct be discontinued and its duties and functions be transferred to the Committee on Questions on Ethics.

3 That the Committee on Veterans Affairs be discontinued

That the Committee on Woman Medical Student and Intern which was set up at the time of the war omergency be discontinued and its func tions transferred to the Committee on Public Health

and Education

5 That the Advisory Committee on Ophthalmological Problems be discontinued We felt that continuing this committee might be setting a precedent whereby perhaps every scientific section in the State Society might want a Council committee simi

lar in nature

6 That the Council Committee on Medical Service and Public Relations henceforth be desig nated as the Council Committee on Medical Service This Council Committee was created at the time the American Modfcal Association set up the parent council At the meeting of the House of Delegates of the American Medical Association held in San erally The interest now being evinced in it is rather a natural outcome of an evolutionary process and reflects today's trends in hospital planning in

general.

The functions of public health and preventive medicine and the functions of curative medicine, while each is an entity in the over-all medical care program, nevertheless, have much in common They require, first, the people who actually do the work—the general practitioners and the physicians practicing in specialties, second, the provision of facilities for doing the work adequately, third, the provision of the ancillary and follow-up services, and fourth, the provision of the administrative organization that will make those facilities and services most effectively available

For discussion purposes a tentative plan has been drawn up which possibly may form a pattern that could well apply to 22 to 24 other counties or areas of this State in the future if the level of interest that appears to exist at this time is maintained. This plan is prepared to serve the particular needs of Schoharie County. This county is one of the areas which our State Medical Society survey in 1945 selected as a prospective site for an experiment in the health center development. As most of you know, it is almost entirely a rural county, located in the Catskills southwest of Albany County. With a ratio of approximately 0.8 bed per 1,000 and 4.5 per 1,000 (3 in rural areas), as the generally accepted figure, we can say that this county's outstanding need is hospital beds, and, consequently, their request seems an entirely appropriate one. (See Appendix "C")

In the Schoharie County plan and in the future where a county might wish to build its health services, starting with the county hospital, it seems entirely justifiable, also, to expect that county to set its Public Health Services in order. It was agreed, after much deliberation, discussion, and conference that the requirements should be that a county has to organize a full county health district before it would be eligible for additional State and in the building of a county general hospital. That important

element is in this Schoharie County plan

The planning, then, envisages a 50-bed hospital to start with, excluding facilities for the chronically ill. with provisions for expansion to 75 beds—which it is believed would eventually be the actual need, also, provision for the inclusion of the county health department—to house it and such clinic services as it may have to operate, and provision for the proper coordination of the services of the hospital and the county health unit. The details of management both lay and medical, still remain to be worked out One of the requirements, however, is that there must be a regularly constituted medical board, just as in any general hospital, and all medical policies, staff appointments, ratings, etc., would devolve upon this board. There would also have to be arranged an affiliation with a regional medical center for the furnishing of the necessary teaching and consultative services The desirability of this relationship to maintain the quality of service in the hospital on the one hand and to enable it to take better care of more patients and to provide the doctors with a center to which they could refer the more complicated and highly specialized problems seems clearly established

The idea is to furnish regularly scheduled consultation services to the hospital staff, not to individual patients but to the hospital staff—in all phases of its operation. Perhaps a similar type of consultation service could be worked out in the field

of nursing administration and that of hospital administration as a whole. It has been suggested as a possible means of financing such service and to prevent unreasonable demands on the specialists' time that the hospital might reimburse these men from hospital funds and enter that expenditure as a legitimate hospital expense. It really is just that, a service to the hospital staff and not to individual patients

This coordinated planning for the integration of the county health department and the county general hospital is on a strictly voluntary basis. The time is appropriate, with these twin programs confronting us, for the Medical Society of the State of New York to reaffirm its endorsement, first of the development of county health units, and second, of the requirement that where State-supported county hospitals exist or may be planned in the future they contain a county health department. We would recommend that they reaffirm this position. Such action is in line with the platform of the American Medical Association.

The Committee is of the opinion that there would seem to be no need in this State for health centers of the so-called nursing unit type with beds for medical care that are included in the plans of the United States Public Health Service. We feel that it would be unfortunate to have health centers of that sort established throughout the State, as it would interfere with the above program of properly organized.

and planned hospitals

The Hospital Council of Greater New York, of which Dr John B Pastore is the Executive Director, is the counterpart for New York City of the Joint Hospital Board for the upstate area. They have made an exhaustive survey of all the metropolitan hospitals and ancillary facilities, and have recently released their report outlining the master plan for guidance in the development of hospitals and related facilities in New York City. It is not within the scope of this report to make any analyses or recommendations on this plan. It is being studied by the five metropolitan county medical societies and appropriate comment will be forthcoming in due time.

The plan was drawn by a committee of eleven authorities after two years of study It is offered in six major sections and stresses that facilities needed for adequate medical care of the people of the city should include, among other things, provisions for general hospital care, acute communicable diseases, convalescent patients, chronic and long-term illnesses, patients with tuberculosis and mental diseases, preventive medicine and ambulant patients Emphasis is placed upon the continuity of medical supervision and the services required by the people irrespective of their economic status The plan recommends, also, extension of present facilities for medical education and training to prepare physicians for present facilities for medical education and training to prepare physicians for present facilities for medical education and training to prepare physicians for present facilities for medical education and training to prepare physicians for present facilities for medical education and training to prepare physicians for present facilities for medical education and training to prepare physicians for present facilities for medical education and training to prepare physicians for present facilities for medical education and training to prepare physicians for present facilities for medical education and training to prepare physicians for present facilities for medical education and training to prepare physicians for cians for practice throughout the country cludes sections on medical research and group prac-Proposals to zone the city and set up regional divisions to bring about closer interhospital relationships are part of its recommendations. This master plan in its major provisions tends to do for Greater New York what the regional planning expects to provide for the State at large The physicians most provide for the State at large directly concerned with the developments of this plan should give it careful study It will bear close scrutiny

The program for the Care of the Chronically Ill is closely hooked up with the planning for new hospitals and expansion of facilities which has just been reviewed Certain principles regarding the care of the chronically ill are so well accepted that they can be considered to be beyond the controversial stage. For the hospital care of the chronically ill the best information that has been guthered up to the present is that between 11/2 and 2 beds per 1 000 population are the basic need. It depends a great deal on what other facilities are going to be made available. If no other institutional facilities are provided, more than that may be needed, but for the legitimate hospital needs of the chronically ill this is the basic number Applied to the Schohare pattern that would mean about 40 beds. Of course the hospital care of the chronically ill is only one phase and recommenda tions regarding improving the home care of these pa tients where the majority will be taken care of and the so-called in between care that is, between hospital and home some institution for those chronically ill persons who do not need hospitale are and who cannot be cared for at home will undoubtedly be forthcoming.

Any program ultimately developed must include education, research, rehabilitation as well as improvement of facilities for the care of chronic ill-

ness.

It must be a cooperative effort shared in alike by the medical profession the nursing profession, hospitals, and all other health and welfare agencies, and must encompass services for the prevention of chrone disease. The Health Preparedness Commission of which Mr Lee Mailler is the general chair man, has been developing for years the Biates a program for the care of the chronically ill. Because this planning is now in an advanced stage and the program nearing completion it would not be justifiable at this time to speak too definitely regarding it. We can, however support these general principles which have been stated

It may be said that the idea of the regional divisions of the State with a chronic descape hospital center as a focal point had its concept in this Commission, and for the purposes of planning this pattern will be followed. It will provide for the designation of special wings, wards, or fleers of general hospitals for the care of chronic illness and, in some instances for separate but contiguous buildings and some formal professional affiliation between such hospitals and the regional chronic disease hospital will be of feeted similar to the consultation services contemplated in the county hospital plan. This phase of medical care however has its own peculiar problems and will require broad perspectives as it reaches into the aspects of convalescent care nursing homes domicillary care and smilar services.

The trend today based largely on the war experence, is toward short hospitalization and this is becoming increasingly ovident in civilian practice. One form of military practice was to transfer patients to a convalencent or rehabilitation section when the acute or definitive stage of treatment was completed By this procedure beds were saved for acute patients and the patients transferred had the advantages of planned convalescent activities and rehabilitation training. Furthermore, the cost of building and operating convalescent homes is approximately half

that of acute hospitals.

The attempt has been made in these summanes to inform you of what is taking place today in hospital planning and related medical caro facilities and to feeus attention more shurply on vital aspects of the situation in our State. Our State Society, representing as it does organized medicine should be keenly alert to all these projects. We have a very definite stake in them. We must exercise the leadership and influence that is rightfully ours by furthering and

cooperating in the advancement and implementation of these plans.

5 United Mine Workers Welfare and Retirement and Health and Hospital Funds -A word of caution would seem appropriate in this report rela tive to possible developments that may grow out of the agreements regarding health practices and welfare and retirement reached between the United Vine Workers and the government in the recent coal mine disputes
promulgated one, the Welfare and Retirement rund, and two the Health and Hospital Fund. Boft coal is mined in 26 states The agreement does not concern New York State at this time except as it concerns the whole medical care problem of the United States Your Committee recognizes in these proposals a new type of economic philosophy which well may influence and possibly change the whole basic pattern of medical practice The principles embodied in these proposals will undoubtedly play an important role in collective bargaining in the future. Their probable extension into fields other than coal mining is obvious and we should be prepared to cope with this rapidly developing situation

The Taft-Smith Ball Donnell Bill -At the March 12 1047 meeting of your Planning Commit tee there took place very considered discussion of S-545 the Taft-Smith Ball-Donnell Bill generally referred to as the National Health Act of 1947 No statement on the Bill or analysis had yet been issued by the American Medical Association Since then, however there has appeared in the March 22 issue of the Journal of the American Medical Association an extensive analysis of the Bill with initial comment and a brief editorial reference. No public hearings as yet have been scheduled for this legislation. It is expected that when such hearings are announced representatives of the American Medical Association will be invited and an official pronouncement will be forthcoming It is hoped, also that constituent State societies may be accorded the privilege of tes-

tifying at these hearings.

With the philosophy of the Bill and with most of its objectives we are in accord. This proposed legislation goes along pretty well with the Program for Medical Care we have already adopted and are sponsoring, and it does afford the means of carrying out some of the provisions of our program. It undoubtedly will need clarification and amendments in certain parts. We feel at this time that we should withhold full approval of this Bill, emphasize our agreement with its general philosophy and purposes and leave ourselves free to suggest changes for improving it

We shall point out in this portion of our report only the highlights of the National Health Act. We urgo again careful reading of the detailed analysis which has appeared in the March 22 issue of the  $J \stackrel{\wedge}{A} M A$  just alluded to

The more aignificant proposals of the Act are

I To collect all the health activities that are now distributed among various government bureaus except those of the Army Navy and Veterans Administration into a single agency. Its administration would be a licensed physician outstanding in the field of modicine, selected by the President and approved by the Senate.

by the Senate
2 Under this physician-administrator of the National Health Agency would be brought the US
Public Health Service transferred from the Federal
Security Agency

3 Provision for including medical indigents in the program by the government paying the premium in voluntary hospital and medical care plans provides further for assistance by the government for those who can pay only part of the premium but

4 Provision for the use of certain funds for physician subsidies to attract and hold competent doctors in rural areas This ties in with the 10-point American Medical Association program It is purely voluntary No state has to come in on it if it does not desire to This provision should materially assist the problem of the better distribution of physiclabs

Emphasis on a medical survey to be conducted by each state to determine its true medical needs, this is patterned after the Hill-Burton Bill hospital These studies would draw \$3,000,000 in surveys federal funds and nould require matching funds

from each state

Provision for withholding from wages of government employees who desire to participate in a voluntary plan This provision is purely voluntary

Transfer of the functions and duties of the Children's Bureau to this agency, removing it from

the Federal Security Administration

Provision for dental health services and the inclusion of a special appropriation for the prevention and control of cancer

The Bill postulates that the National Health Agency shall be composed of the following

The Office of the Administrator

The Public Health Service, which in turn shall assume the administration of St Elizabeth's Hospital and Freedmen's Hospital The Office of Medical and Hospital Care

Services

The Office of Dental Care Services

The Office of Maternal and Child Health

The Office of Health Statistics

The Office of Food and Drug Administration

Such other constituent units as the Administrator finds necessary

All of these units would be ranked equally and nould rome directly under the Administrator of the

National Health Agency
The Director of the Office of Medical and Hospital Care Services would be a doctor of medicine, licensed to practice medicine in one or more states, who had had at least five years of active medical practice, and who was outstanding in the field of medicine would be in immediate charge of the medical grants-in-aid program. He would rank administratively with the Surgeon General of the Public Health

A National Medical Care Council, of which the Director would be a member ex officio, would consult with him in administering the grants-in-aid program. This Council would consist of eight members in addition to the Director, four of them physicians appointed by the National Health Agency ad-

This Bill, S-545, recognizes throughout the prin-

ciple of local responsibility and local control
7 Two other bills, S-140, known as the Full-bright-Taft Bill, and S-712, the Aiken Bill, have been introduced into the 80th Congress and hearings are being held on both

The Fullbright-Taft measure would create a Department of Health, Education, and Security in the Federal Government The new department would be administered by a Secretary of Health, Education, and Security to be appointed by the President, by and with the advice and consent of the

Senate, and by three undersecretaries similarly appointed The Undersecretary for Health would be a doctor of medicine "who shall perform such duties concerning health as may be prescribed by the Secretary or required by law" The Office of the Federal Security Administrator and the Federal Security Agency and its constituent units, together with all their powers, functions, and duties, would be transferred to the new department

S-712, introduced on February 26 by Mr Aiken of Vermont, is a bill to constitute the Federal Security Agency a Department of Health, Education, and Security It was referred to the Committee on Expenditures in the Executive Departments Bill would convert the Federal Security Agency into an Executive Department of Health, Education, and Security to be administered by a secretary with Cabinet rank and an undersecretary, and two assistant secretaries, all to be appointed by the President with the advice and consent of the Senate No provision is made for separate administration for the three included activities

These bills would interpose a lay intercessor between the health division in the new department and the President He could and probably would prescribe what the health and medical division or bu-

reau would do

Dr E S Bagnall, of the Massachusetts Medical Society testifying before the House Committee on Expenditures, told them that his state had tried combining health and welfare and it had not worked He contended that physicians were at a disadvantage with social workers in the matter of governmental setups. Social workers often were "on the career jobs which evolved these plans," whereas medical men were individualists who combined publie work with medical practice. He predicted that the proposed new Cabinet post of Health, Education, and Security would be foredoomed to failure He advocated the Taft-Smith-Ball-Donnell Bill setting up the National Health Agency, which, he

said, might develop into a Cabinet post Dr R L Sensenich and James R. Miller of the Board of Trustees of the American Medical Association testified, also, that health should have a cabinet post of its own They stated that the American Medical Association was opposed to the proposed Department of Health, Education, and Security and said, further, that if a Cabinet post for health was not now attainable the American Medical Associa tion would back the Taft Bill to create the new Na tional Health Agency They expressed the fear that if the field of health were combined in federal classi fication with education, now widely recognized as in need of more funds, and with welfare, also requiring more funds, "nothing will happen but stagnation" so far as health is concerned. They contended further that the lumping together of these three departments nould lower the quality of health services to the people Although the American Medical Association has long advocated a Department of Health with Cabinet status it is greatly concerned that such a post might be a step toward socialized medicine if unlimited power were put in the hands of a lay Cabi net secretary

We would reaffirm our position that health and medical functions within the federal government be under medical control. The thinking and planning of social and welfare workers and some spokesmen for organized labor are so predominantly at variance with the ideals and philosophy of American medicine that any such grouping of these functions as con-templated in this legislation would be detrimental to public and professional welfare alike It is logical to

assume that such an agency would be dominated by these groups in this country that would go all out for national compulsory sickness insurance. We should support atrongly those legislative proposals which would separate health and medical functions from the control of the Federal Security Agency

With the position of the American Medical Association in relation to this proposed legislation we are

in complete accord,

8 Group Practice—The Planning Committee in the 1946 report to the House of Delegates presented a general survey of this subject and included 'a set of principles for group practice approved by the Coordinating Council of the five County Medical Societies of New York as of November 1 1945' In summary the action which we took last year is as follows:

"These principles are incorporated in this report as Appendix B. They constitute a reasonably sound framework which should guide the organization of any group. The Planning Committee approves these aforementioned principles. Organized modleme is frequently criticized as opposing group practice. We should like to correct that impression. Medicine does approve group practice but insists it should be conducted on a highly ethical plane and should conform to such basic principles as those conformation in Appendix B.

"The Committee feels also that the formation of any group is entirely a local problem and should adapt itself to the cituation in each community We cannot recommend at this time any particular

type of group practice

An increasing interest in group practice is taking place because there is much thinking on this method of practice, especially by those younger physicians returning to practice after service in the armed forces and by the new graduates and young interns because of the indoctrination in this phase of practice they are receiving. Recently two bills passed the State Legislature and have been signed by the Governor One will permit physicians to practice in partnerships and to pool fees The other measure allows under the provisions of 0-C of the Insurance Law, the employment of physicians by nonprofit medical indemnity and hospital service corporations to treat persons insured by them. The State Society opposed this legislation not in principle, but because we felt that the bills were loosely drawn and opened up avenues for fingrant violations of medical ethics and that they would be contrary to the best interests of the public. It is not unlikely too that such a proposed system might cause a deterioration of the quality of modical and hospital care through the elimination of the principle of free choice of physician.

In the minds of the members of this Committee this subject of group practice is one in which the State Society should show increasing concern. We therefore recommend that this House of Delogates authorize the Council to have drafted suitable legislation to cover the matter of partnerships and group practice within the principles already approved by the State Society and that in the drafting of this proposed legislation other interested agencies be consulted and their aid and cooperation solicited.

In conclusion the attempt has been made to abstract and correlate from the mass of material coutsined in the minutes of the meetings of this Committee and in the proceedings of the conferences participated in by its chairman and others of its members the salient and perthent data which might

assist this House of Delegates in its deliberations and decisions. Annual reports, studies by similar groups working in these fields reliable press releases and other sources of information have been freely consulted. Although this has been no inconsiderable task, it has proved a stimulating one. Omissions have necessarily occurred nevertheless in its scope and detail the report is believed to cover the executial facts of those subjects which we have reviewed.

Uppermost in the minds of people today is socurity. Opportunity challenge initiative, seem to be forgotton words. The individual is being throttled for the blanket protection of the mass. The psychology of the times is to lull him with a sense of security and at the same time to take away the incentive and opportunity for individual initial tive. This road leads only to more and more regimentation and finally through logislative security to full State control

Medicine in this changing order must preserve and maintain its independence and freedom of action. This position is succincily and simply stated in the following quotation from the leading editorial in the NEW YORK STATE JOURNAL OF MEDICINE for April I

Medicane must preserve its fluidity it must be able to adapt itself functionally to the real, the demonstrable needs of a changing economy a changing social structure and to make its own constantly improved technology and practice readily available to the sick. It must be pealous of its own independence of thought and action but with out arrogance it must remain free from the clutching claws of a ruthless and stullifying bureaucracy it must scrutnize closely all proposals for change to be sure that such are practical and not merely apparently so "

The Chairman takes this opportunity to thank sincerely all the members of this Committee for the faithful attendance at its meetings and their valuable contributions to its deliberations. Without their fine cooperation this work could not have been accomplished

To Mrs. Augusta L. Grimm, Miss Doris Doug herty, and her associates on the office staff, also, go the thanks of the Committee for their loyal cooperation and assistance at all times

Respectfully submitted,
J STANLEY KENNET M D Chairman

#### Appendix A

The National Health Program of the American Medical Association

1 Minimum standards of nutrition housing, clothing and recreation are fundamental to good health.

2. Preventive medical services should be available to all and should be rendered through professionally competent health departments. Medical care to those unable to provide for themselves should be administered by local and private agencies with the aid of public funds when needed preferably by a physician of the patient's choice

3 Adequate prenatal and maternity care should be made available to all mothers. Public funds when needed should be administered by local and

private agencies

4 Every child should have proper attention including scientific nutrition immunization and other services included in infant welfare. Such services are best supplied by personal contact between

the mother and the individual physician but may be provided through child health centers administered locally with support by tax funds whenever the need

can be shown

Health and diagnostic centers and hospitals necessary to community needs are preferably supplied by local agencies When such facilities are unavailable, aid may be provided by federal funds under a plan similar to the provisions of the Hill-Burton Bill

Voluntary health insurance for hospitalization and medical care is approved, the principles of such insurance plans to be acceptable to the Council on Medical Service and to authoritative bodies of state

medical associations

Medical care, including hospitalization, to all veterans should be provided preferably by a physician of the veteran's choice, with payment through a plan agreed on between the state medical association and the Veterans' Administration

Research for the advancement of medical science, including a National Science Foundation, is

endorsed

Services rendered by volunteer philanthropic

health agencies should be encouraged

10 Widespread education in the field of health, and the widest possible dissemination of information regarding the prevention of disease and its treatment are necessary functions of all departments of public health, medical associations, and school authorities

#### Appendix B

#### General Recommendations to House of Delegates General Recommendations

The Council on Medical Service of the American Medical Association in its report to the present ses sion of the House of Delegates deals generally with this subject as follows

"At the request of the Board of Trustees, the Council has contacted the state medical societies in an effort to impress upon them the importance of preparing a plan of cooperation for putting into effect the provisions of the Hill-Burton law When the states have completed the hospital survey and the material has been placed in the hands of the American Hospital Association the results of these surveys will be utilized in developing a statewide hospital construction plan What part the medical profession plays will depend upon its preparedness and willingness to cooperate with other groups in utilizing funds provided for in the As a service to the states, the Council is preparing a statement of principles as a guide to such cooperation and a set of minimal standards for diagnostic clinic facilities Because of the extreme inportance of this program, the Council presents the following recommendations to the House of Delegates

"The importance of the Hill-Burton Hospital Construction law in the over-all program of medical and hospital care should be recognized by all

medical societies, state and county

"The medical profession, through its state and county medical societies, should be encouraged to participate actively in plans or programs formulated under the act

"This participation should include an early review of the membership of the advisory council to the state agency charged with the responsibility of carrying out the provisions of the law in order to determine the adequacy of medical representation. If necessary, action should be taken by the state medical association to obtain acceptable medical representation

"This participation should include a positive effort to see that local autonomy is maintained, that facilities are placed only where a specific need for them is shown, that any diagnostic clinic facilities be creeted only with the approval of the county medical society in whose area they are placed "

#### Appendix C

#### Summary

General Hospital Facilities1 in New York State in Relation to Hospital Service Regions and Districts and Population? Bed Ratios

JOINT HOSPITAL BOARD
NEW YORK STATE POSTWAR PUBLIC WORKS PLANNING COMMISSION
September 18 1946

#### EXISTING GENERAL HOSPITALS

Hospital Regions  Albany (16 counties 6 districts) Syracuse (15 counties 9 districts) Rochester (11 counties 5 districts) Buffalo (6 counties 3 districts) Northern Extra Metropolitan (7 counties 4 districts) Long Island (2 counties 3 districts)	Number of Hospitals 42 54 36 32 41 21	Number of Beds 3 612 5 320 4 105 4 701 4 514 1 665	Estimated 1945 Population 1 032 002 1,317 073 879 600 1 300 467 995 320 051 058	Ratio <sup>3</sup> General Hospital Beds per 1 000 Population 3 50 4 39 4 67 3 01 4 53 2 56
Total Upstate (57 counties 30 districts) New York City (5 counties)	226 126	23 917 32 841	6 177 520 7 730 383	3 87 4 25
Total State (62 counties)	352	56 758	13 907 903	4 08

List includes many small institutions listed as hospitals which do not provide modern general hospital facilities
 1945 population estimates New York State Department of Commerce
 4 5 beds per 1 000 population most widely accepted

#### ALBANY REGION

		General Hospitals—— Number			Ratio
Counties	Hospital Service Districts	of Hospitals	Number of Beds	Population	General Hospita Bods per 1,000 Population
Clinton Errez	Plattaburg-Secondary Center	2 6	316 148	43,277 31,335	4 00 4 73
Warren Washington Baratoga	Glens Falls—Secondary Center	1 2 3	136 116 131	37 178 43,3 8 67 150	2 66 2 68 1 95
Hamilton Fulton	GloversvilleSecondary Center	0 1	133	3 413 48,*41	0 2 76
Montgomery Schenectady	Schenectady—Secondary Center	2	239 400	57,876 135,287	4 13 2 96
Otzego Delaware	Oneonta—Cooperstown Secondary Center	3 7*	193 113	44,386 37 048	4 35 3 05
Greene Columbia Schoharie Renewelaer Albany	Albany—Primary Center	1 2 4 8	70 135 16 008 038	20,578 87,789 20,298 1°0,880 °77,088	3 58 0 79 5 03 3 46
Total 16 counties	6 districts	4	3 612	1,032 002	3 50

#### BYRACUSE SECTION

			Rati General Hospita		
Counties	Hospital Service Distri te	Number of Hospitals	Number of Beda	Population	Beds per 1 000 Population
Franklin	Saranae Lake-Secondary Center	3	150	44 122	3 60
St. Lawrence	Ogdensburg Secondary Center	8	329	90,535	3 63
Jefferson Lawis	Watertown-Secondary Center	5 1	354 44	83 630 21 500	4 23 2 05
Oneida Herkimer	Utien-Secondary Center	8	1,039 190	211 174 61 411	5 18 8 09
Tioga Broome Chenango	Binghamton—Becondary Center	1 5 6	07 1 004 124	26,831 175,301 37,336	7 80 5 73 3 81
Oswego Osondaga Cayuga Madison Cortland Tompkine	8yracuse—Primary Center	2 7 2 3 2 2	137 1 10° 209 117 143 158	05,867 309 827 69 728 40 935 32,345 43,331	1 99 3 36 4 28 2 86 4 42 3 60*
Total 15 counti	es 9 districts	54	5,320	1,817 073	4 30

<sup>\*</sup> Cornell University Infirmary of 154 beds omitted from compilation

#### ROCHESTER REGION

		——General I	lospitals——		Ratio General Hospital
Counties	Hospital Service Districts	of Hospitals	Number of Beds	Population	Beds per 1,000 Population
Orleans	Rochester-Primary Center	2+	58	20,903	1 94
ylenroe	Monroe County	3	32	116,843	0 27
Wayne Livingston	Rochester City	4 2	2,357 109 5-	333 44 53 557 33 761	7 07 2 04 1 54
Ontario Beneca Yates	Clifton Springs—Secondary Center	3 2 1	497 55 80	52 707 24,957 16,170	9 43 2 20 3 0J
Schuyler Chemung	Clmira-Secondary Center	1 3	36 436	12 4 1 81 043	2 90 5 <b>3</b> 8
Allegany Steuben	Hornell-Secondary Ce ter	3 5	95 325	39,583 85 151	40 3 55
Total 11 countles;	4 districts	30	4 105	879 600	4 67

<sup>\*</sup> Excludes county hospital at Albion 54 beds really chronic custodial care.

## BUFFALO REGION

		General I	Hospitals		Ratio General Hospital
Counties	Hospital Service Districts	of Hospitals	Number of Beds	Population	Beds per 1,000 Population
Génesee Wyoming	Batavia-Secondary Center	2 1	142 122	44,750 29 415	3 17 4 15
Niagara		4	543	179 844	3 02
Erie	Buffalo—Primary Center Erie County Buffalo City	3 11	204 3 004	245 006 611,336	0 83 4 91
	Total Erie County	14	3 208	856 342	3 76
Chautauqua Cattaraugus	Jamestown—Secondary Center	6 5	401 285	123,297 68 819	3 25 4 14
Total 6 counties	3 districts	32	4 701	1 300 467	3 61

#### NORTHERN EXTRA METROPOLITAN REGION

Ulster	Kingston—Secondary Center	2	228	81,930	2 78
Dutchess Putnam	Poughkeepsie—Secondary Center	5 1	431 45	106 896 15,773	4 03 2 85
Sullivan Orange Rockland	Middletown—Secondary Center	5 8 3	111 581 199	34,568 132 142 63 060	3 21 4 40 3 16
Westchester	White Plains—Primary Center	17	2 919	560,951	5 20
Total 7 counties	4 districts	41	4 514	995 320	4 53

#### LONG ISLAND REGION

Nassau	Hempstead—Secondary Center	12	895	456 225	1 96
Suffolk	Bay Shore—Secondary Center	9	770	194,833	3 95
Total 3 countie	s 3 districts	21	1,865	651 058	2 56

(To be continued in the August 15 issue)

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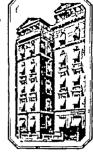
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# DEPARTMENT OF THE VETERANS MEDICAL SERVICE PLAN, INC.

## Operation of Veterans Medical Service Plan

TWO questions have arisen recently—one, regarding the issuance of prescriptions by private physicians to veterans under the Veterans Administration Pharmacy Service Plan, and the other, regarding the Veterans Administration limitation on double appointments of doctors, dentists, and nurses, and on the annual salary which one doctor, dentist, or nurse may earn on a part-time or fee-basis through his association with the Veterans Administration

With reference to the first question, the circumstances are as follows. In issuing a prescription to a veteran under the Veterans Administration Prescription Service, a private physician is required to sign on the prescription a legend which reads, "I am authorized to treat and prescribe for the abovenamed VA beneficiary." Throughout the nation, it has commonly occurred that private physicians is sued prescriptions to veterans, with the signed legend, without actually holding an authorization from the Veterans Administration to treat the veteran for a service-connected disease or disability. In these cases, druggists have filled the prescriptions in good faith, only to have payment denied by the Veterans Administration because the veteran's treatment was not authorized.

It should be emphasized that a private physician should not issue prescriptions bearing the VA legend to veterans unless he holds a current VA authorization to treat the service-connected illness or disability for which the prescription is written Nonobservance of this rule may constitute a violation of

Federal Statutes

Any private physician who finds it necessary to prescribe for a VA beneficiary for whom authorization for treatment has not been obtained should

1 Mail, or suggest that the veteran mail, the prescription to the nearest VA medical installation

for filling, or,

2 If a medical emergency exists, mark the prescription "emergency" for filling locally, without signing the standard authorization legend Prescriptions marked "emergency," however, cannot be filled without cost to veterans under the terms of the existing VA agreement with the New York State Pharmaceutical Association The veteran in these circumstances may apply to the Veterans Administration for reimbursement of the cost of the prescription, which will be granted if the condition prescribed for is found to be service-connected

The second question of Veterans Administration policy is that which concerns the employment of part-time or fee-basis doctors, dentists, and nurses The main provisions of this policy are as follows

1 A limitation of \$6,000 is placed on the maximum per annum salary of physicians, dentists, and

nurses who are employed by the Veterans Administration on any but a full-time basis. This ruling applies to physicians who treat veterans under the Veterans Medical Service Plan of New York and receive fees from the Veterans Administration for their services. In addition, physicians employed on a part-time basis by the Veterans Administration are not to be permitted to treat VA patients on a fee-basis during the hours in which they are engaged in private practice.

2. The maximum \$6,000 applied select limitation.

2 The maximum \$6,000 annual salary limitation is applicable to individual doctors, dentists, and nurses regardless of the number of separate Veterans Administration appointments he or she may hold during the year and regardless of whether the appointments ran consecutively, concurrently, or remain separate and distinct. In addition, the limitation is applicable whether or not such separate appointments are held at different Veterans Adminis-

tration installations

3 Rates of pay for WAE (when actually employed) and per diem consultants and attending physicians are limited to \$50 and \$25 per day or fraction thereof, respectively. The \$6,000 maximum per annum salary limitation is applicable to consultants and attending physicians if they are appointed for a period of a year or more. If the appointment is for less than a year, the maximum limitation is prorated in accordance with the length

of their appointment
4 Doctors, dentists, or nurses may not hold
more than one type of appointment with the Veterans Administration at one time. This applies to
temporary, full-time, part-time, consultant, attending, or fee-basis appointments. However, at the
direction of the Branch Medical Director, consultants appointed on the rolls of the Branch Office (846
Broadway, New York City) may be utilized at different field stations when consultants in the same
specialty are not available at field stations when
their services are needed

5 Payment of both a VA fee and VA full or parttime salary is not to be made for service rendered at the same time or on the same day, regardless of how the doctor, dentist, or nurse is appointed or the circumstances under which the services were rendered

or emergencies included

6 Any exception to the policies outlined above must be initiated and recommended by the Manager of the Veterans Administration Regional Office under whose jurisdiction the services in question are performed

C F Von Salzen, M D
Acting Branch Medical Director

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Dr Luther B MacKenzie recently was awarded the Alumni Meritorious Service Medallion for "distinguished service to New York University" Dr MacKenzie serves on the Board of Trustees of the New York County Medical Society, and on the Publication Committee of New York Medicine

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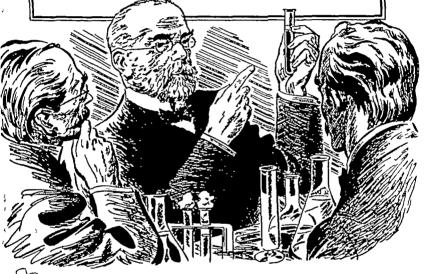
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NUMBER 16

Published twice a month by the Medical Society of the State of New York Publication Office 20th and Northampton Sts, Easton, Pa Editorial and Circulation Office 292 Madison Ave, New York 17, N Y Change of Address Notice Should State Whether or Not Change is Permanent and Should Include the Old Address Twenty-five cents per copy of per year Entered as second-class matter March 13, 1939, at the Post Office at Easton, Pa, under the Act of August 24, 1912

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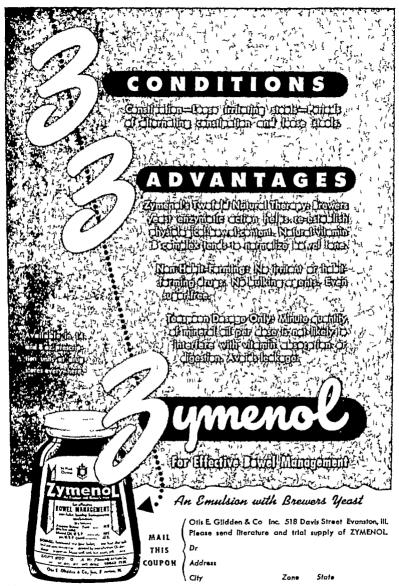


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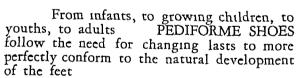
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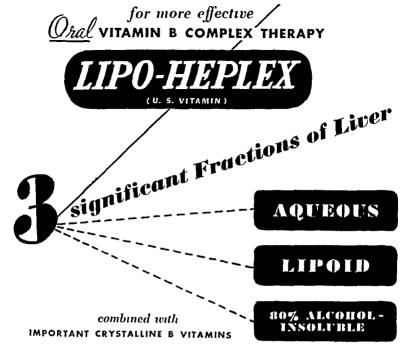
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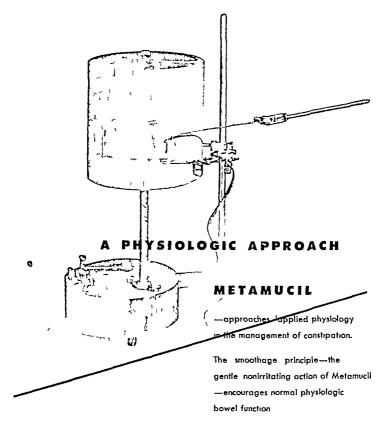
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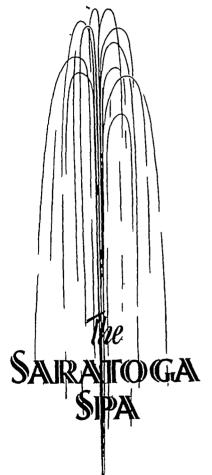
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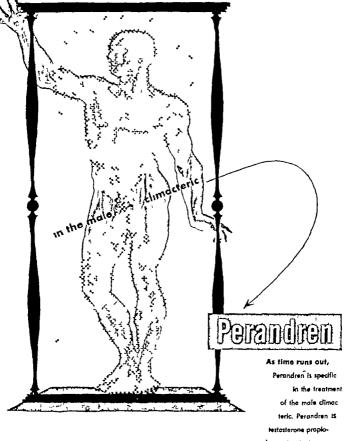
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"custom-made" Protection, designed to meet the described needs of each particular case? Physicians, who know from experience, can tell you that Rice "custom-made" Supports for reducible HERNIA are truly different and that our methods are dependable. With dozens of different styles, shapes and types of pads at our disposal and with a full realization of our responsibility to those who put their faith in us—we respectfully offer our services for your approval. Descriptive literature and measurement charts on request.

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Each Enforbec tablet provides truly \* THERAPEUTIC doses of all of the

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"Treatment for a deficiency involves administration of large enough doses of the vitamin to be of therapeutic value and continuation of this treatment for long enough periods to assure a satisfactory therapeutic trial \*

Council on Foods and Nutrition Vitamin Deficiencies Stigmas, Symptoms and Therapy J.A.M.A., 131 666 (June 2.) 1946.

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Riboflavin (B2)	5 mg.
Niacinamide	100 mg.
Pyridoxine HCl (B <sub>6</sub> )	01 mg.
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Ascorbic Acid (C)	100 mg.

Pius additional factors of the vita min B complex present in liver B fraction and yeast

Coated hexagonal tablets of distinctive appearance and pleasing flavor and odor Bottles of 100

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# The Impetus Required

# IN SLOW-HEALING WOUNDS

Indolent ulcers,

Indolent ulcers,
Burns, Infected
Surface wounds,
Non healing
Lesions

The value of local therapy in chronic skin ulceration lies in speeding up the healing process and there by shortening the period of disability, and in procuring an end result which is as nearly normal and free from dis figuration as possible

To these ends Morruguent and Morumide Ointments lend themselves admirably — The active ingredient of Morruguent is cod liver oil concentrate (with a 25% greater content of the unsaponifiable fraction than that contained in cod liver oil USP) In Morumide, sulfamilamide (10%) has been incorporated, in addition, for its bactericidal action

Cod liver oil lowers the vitality of pyogenic organisms, sulfanilamide is an active bactericide. These preparations prevent or retard infection on an ulcerated surface, reduce systemic absorption of toxic metabolites, hasten granulation and epithelization, and make for a pliable, elastic epithelial surface. Healing takes place with a minimum of surface disfiguration.

Morruguent and Morumide Ointments are indicated for topical treatment in chronic indolent ulcers, burns (of any degree), suppurating wounds, non-

healing amputation stumps, and similar lesions of the skin



THE S E MASSENGILL COMPANY

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Comes summer comes hay fever comes Neo-Synephrine for relief

Decangestion of nasal and ocular edema occurs promptly lasts for hours hypersecretion and excessive lacrimation are quickly checked days are more comfortable nights more restful.

# Neo-Synephrine

### For hay fover velief

INDICATED for relief of the nesal and ocular symptoms of hay favor stouchts and summer codes.

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Consistently Zero!



CLINICAL ADVANTAGE IN FEEDING THE PREMATURE

Because Similac, like breast milk, has a consistently zero curd tension, it can be fed in a concentrated high-caloric formula without fear of increased curd tension and lengthened digestive period. Hence, premature infants unable to take a normal volume of food may safely be fed a concentrated Similac formula supplying as much as double the caloric value (per ounce) of the normal dilution. The use of a concentrated formula often avoids serious loss of weight and manition in the premature infant, and permits a more rapid return to normal weight gain.

M & R DIETETIC LABORATORIES, INC . COLUMBUS 16, OHIO

SIMILAC

Similar to milk breast milk



A powdered modified milk product especially prepared for infant feeding, made from tuberculin tested cows milk (casen modified) from which part of the butter fat has been removed and to which has been added lactose coconnut oil cocoa butter corn oil and olive oil Each quart of normal dilution Similac contains approximately 400 U.S. I units of Vitamin D and 2500 U.S.P units of Vitamin A as a result of the addition of fish liver oil concentrates

# Nutritive Capsules

LNP - June 15 EDC - March 22

Gestation

from conception until the actual date of confinement-places unique demands upon the mother. Not the least important of these are accentuated mineral and vitamin needs

To spare the mother the burdens of cumbersome supplementation and the dangers of nutritional inadequacy NUTRITIVE CAPSULES afford in convenient form efficacions dosages of Dicalcium Phosphute

(Anhydrous) Ferrous Sulfate Vitamin B (Thiamine Hydrochloride) Vitamin Bi (Riboflavin) and Vitamin D Similarly NUTRITIVE CAPSULES prove highly advantageous to the conva

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NUTRITIVE CAPSULES are one of a long line of Parke Davis preparations whose service to the profession created a dependable symbol of therapeutic significance - MEDICAMENTA VERA

NUTRITIVE CAPSULES are supplied in bottles of 100 and 1000



# "FLAVETTES"\*

# To Curb The Appetite Is Available

Each tablet contains Benzocaine 1/20 grain flavored with Saccharin, Extract of Licorice, Powdered Ginger and Oils of Anise, Wintergreen, Peppermint, Conlander and Cloves

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Capitol Station

Albany, New York

\*Gould Wm L New York State Journal of Medicine 981-983 May 1 1947

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Actively alkaline Contains no narcotics, no injurious drugs Consists of alkali salts, fruit acids, and sugar, and makes a pleasant effervescent drink

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with deep empiric roots...

Modern authoritative reports 12 highlight the practical value of phosphates of soda for thorough (yet mild) elimination whenever it may be indicated. They serve to illustrate the reason why Phospho-Soda (Fleet)\* for over a half-century has enjoyed such a steadily increasing clinical acceptance as an ethical cathartic of exceptional ment Palatability ease of administration and gentle yet efficient laxation-with remarkable freedom from nausea griping and anal irritation make Phospho-Soda (Fleet)\* truly a "modern physician's laxative Its formula combines two recognized phosphates of soda in scientific proportions in stable uniform and highly acceptable liquid form Promoted to the medical and dental professions only, available in 21/2 6 and 16 fluid ounces at pharmacles everywhere

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References

1. Scherer, J. H.: Virginia M.,
Monthly, 72:289, July, 1945,

2. Travell, J. et al.: Conferences
on Therapy, New York Stella

C B FLEET CO, INC

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For Controlled Catharsis Prescribe
PHOSPHO-SODA
(FLET)



# for the patient with distressing urinary symptoms

The prompt symptomatic relief provided by Pyridium is extremely gratifying to the patient suffering from distressing symptoms such as painful, urgent, and frequent urination, nocturia, and tenesmus

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For Speedier Recovery
In ANEMIA

Combining the therapeutic effects of iron with adequate amounts of other essential nutrients makes for speedier and more efficient recovery in hypochromic anemia

Frequent occurrence of multiple vitamin deficiencies in patients with hypochromic anemia makes it especially desirable to supplement specific iron medication with adequate amounts of all the lacking vitamins. Iron alone is inadequate.

The Heptuna formula is based on this rational approach to anemia therapy

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Ferrous Sulfate U S P 4 5 Grains

Vitamin A (Fish Liver Oil) 5 000 USP Units

Vitamin D (Tuna Liver Oil) 500 U S P Units

Vitamin B<sub>1</sub> (Thiamine Hydrochloride) 2 mg

Vitamin B<sub>2</sub> (Riboflavin) 2 mg

Vitamin B<sub>4</sub> (Pyridoxine Hydrochioride) 0 1 mg Calcium Pantothenate 0 333 ma

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Together with other B-complex factors from liver and yeast







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### PREMO NEBULIZER

The Preme Nebulizer embedies a new principle which allews for hand nebulization of 50,000 units of Penicillin solution (McC) in 2 to 3 minutes. The nebula particle size is from 0.5 to 2.0 microns.

Supplied Combination Package, 1 Premo Nebulizer and 12 Penicillin Nebutabs

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#### To Give Him a Good Start

We ve worked with the profession for more than three generations to develop milk food for bables. Nestlés Evaporated Milk has the nutritive value of whole cows milk—plus something extra Every pint supplies 400 USP units of pure Vitamin D3 the full daily minimum required by infants.

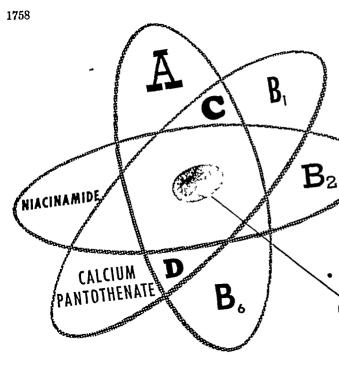


### Nestlé's Has the "Know-How" to

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- Nestle s was the first evaporated milk fortified with 400 U S P units of genuine Vitamin D<sub>2</sub> per pint.
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No wonder so many doctors recommend **NESTLÉ'S** Milk by name



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VITAMINS in the

nutritional orbit

..in potent, balanced
economical, easy-to-take

capsules

Rich or poor, young or old, farmer or city dweller, people of above-average intelligence, even physicians—the diet of every strata of the U S population has been weighed in the nutritional balance and found wanting in health-essential vitamins Deficiencies are almost always multiple.

MORE VIGOROUS HEALTH may be derived by patients with vitamin-poor menus, by fortifying their diets once daily with



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min Bo	,)	0.5 mg
t .		5 mg
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So easy to take youngsters swallow them readily—so high in potency and easy on the purse, patient appreciate their economy.

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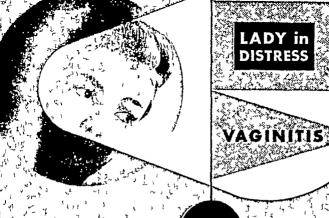
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AMERICAN PHARMACEUTICAL COMPANY

1 Bulletin National Research Council Nov 1943

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Speedy relief from Itching discharge, foul odor, etc.

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the ideal base' !- adhesive consistency and wetting power assures sustained

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"Buffered effectively" to promote correct mucosal acidity, Doderlein's bacilli growth, a healthy vaginal flora

to accelerate healing" (—highly sulfathiozole-active for speed-up in healing time

"As easy as possible to apply" (1) in office and at home for sustained patient cooperation

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PHARMACAL CORP



# Putting <u>palatability</u> into <u>hig</u>h-protein diets

# Swift's Strained Meats



### Prepared originally for infant feeding now used extensively for special diet cases

Good food plays a psychologically as well as a physiologically important part in aiding recovery. This is one reason so many doctors are now using Swift s Strained Meats for patients on high protein low residue diets containing chemically and physically non irritating foods. Swift's Strained Meats provide a palatable natural source of complete high-quality proteins, B vitamins and minerals for patients whose condition prohibits the use of meats prepared in the ordinary mainer. Each of the six kinds beef lamb pork, yeal liver and heart offers a tempting distinctive meat flavor more readily accepted by patients even when normal appetite is impaired.

### Lean meat—strained fine enough for tube feeding

Swift s Strained Meats developed originally for feeding to young babies are prepared from selected lean U S Government Inspected Meats They are carefully trimmed to reduce fat content to a minimum. The meats are slightly

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the nipple of a nursing bottle may easily be
used in tube feeding. Convenient to use—espe
cially for patients at home—Swift a Strained Meats
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#### Swift's Diced Meats—tender julcy cubes

For soft smooth high protein and low residue diets these small cubes of lean meat offer new convenience and appetizing variety. Swift's Diced Meats are tender juicy pieces of meat easily mashed into smaller particles if desired. 5 ounces pet tin.

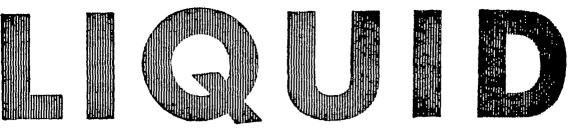
We will be glad to send you further information about Swift's Strained and Suff's Diced Meats with samples Write Swift & Company Dept BF Chicago 9 Illinois.

> All nutritional statements made in this advertisement are accipied by the Connect on Poods and Nationan of the American Medical Association.



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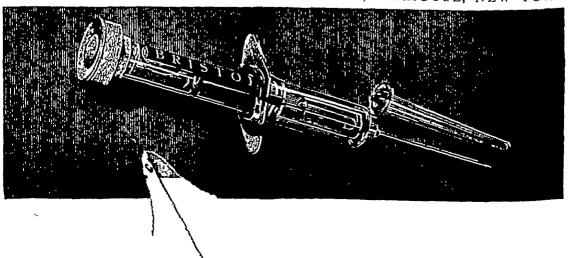
Now you can inject Bristol's Crystalline Sodium

Penicillin G in Oil and Wax (Romansky Formula) with far greater ease than in the past Due entirely to changes in the manufacturing process and without any alteration in formula, the viscosity of the product at room temperature has been brought to a point which approximates that of U S P glycerin This is a significant development in penicillin therapy Specify Bristol and obtain the benefits of LIQUID Romansky Formula

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SORPARIN has been found to provide valuable support for the liver Sorparin apparently admitted the liver cells to increased activity depails both vitamin K like activity it increases blood producemble levels. It has been found of value and the light the symptoms of gastric discomfort fredering the concomitant with hepatic deficiency.

Nontoxic and non kinetic. Has no known contraindi cations May be prescribed in obstructive conditions,

### SORPARIN

(Ext. So bus aucuparia McNell)

INDICATIONS • Hepatitis with or without jaundice
• Idiopathic hypoprothrombinemia • Post surgical biliary syndrome • Indeterminate dyspepsias
• Sorparin is also useful for mild liver dysfunction secondary to such conditions as chronic cholecystitis.

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Natural Estrogens in Crystalline Form

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# NEW YORK STATE **JOURNAL OF MEDICINE**

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**VOLUME 47** 

AUGUST 15, 1947

NUMBER 16

# Editorials

## Atomic Energy and World Health

Current emphasis as might be expected centers on the military aspect of the use of atomic energy The atomic bomb, with its potentialities as an instrument of destruction, has been demonstrated, pictured, exhaustively described in all its physical, political, and social aspects as perhaps no single military weapon has been before There is little probability that public ignorance of this phase of the use of atomic energy can still exist At the moment, official statements concerning the dangers of the uncon trolled use of fissionable materials seem to be realistic

This realism is commendable and will appeal to doctors If as citizens we have to prepare to use a new modality destructively. it is dangerous and futile to becloud the issue. Complete comprehension by the pubhe and forthright speaking by responsible officials are necessary and welcome expects immedate success in the procurement of permanent world peace by any arrangement that could be made But the United Nations has undoubtedly made considerable progress in many directions in the baleful ahadow of the atomic bomb

Elmo Roper has written pertinently 1

We are prone always to regard obstacles in the path of progress as both insurmountable and of a new kind-forgetting our history It might con sole those who are discouraged by the rocky na ture of the United Nations path to remember our own efforts to form the United States stitutional Convention was held in 1787 Sev. enty-four deputies had been appointed by twelve of the states-Rhode Island refused to appoint Only fifty-five attended and of these any fourteen left before the Convention closed and three more refused to sign During 1787, only three states ratified the Constitution—and one of these Pennsylvania, only by a 43 to 23 vote. Eight more ratified in 1788 but the proposition had a narrow squeak in New York, where the vote was 30 to 27 for adoption. It was not until 1790 when Rhode Island came through by a 34 to 32 vote that all thirteen original colonies ratified the Constitution

The union of thirteen colonies which had just finished fighting shoulder to shoulder for freedom and all of which had the advantage of a common language and lay side by side in one continent was not achieved easily nor without dissent. Cortainly we should not be too easily discouraged about the United Nations.

<sup>1</sup> N Y Herald Tribune, Sept. 8, 1946.

One of the most hopeful things the United Nations has done is to set up the World Health Organization Charter as a means of implementing one of its objectives

If one views the potential destructiveness of the atomic bomb, one should likewise consider its constructive possibilities

World Health A restless peace with its diminishing clash of armaments creates a partial vacuum Into it have been sucked and concentrated all the major disagreements of men and nations Together with the atomic bomb, these disagreements have received the lion's share of publicity what of the things on which men and nations can and do agree? These far outnumber their differences Yet, they, too, are threatened by the destructiveness of the atomic This fact may serve to correct some of the misconceptions concerning them that they are humdrum, lack drama, are drab and technical

World Health and its benefits have been singularly well served by Dr Thomas Parran, former Surgeon General, USPHS, and President of the International Health Conference, in his closing address last year <sup>2</sup>

The nations represented here today are signing a Magna Carta for health which will bring into being a world health organization unique in its scope, authority, and functions. Its broad purpose is the attainment by all peoples of the highest possible level of health and well-being. We are convinced that health is not merely the absence of disease or infirmity but a state of complete physical, mental, and social well-being—the enjoyment of which we declare to be a fundamental right of every human being without distinction of race, religion, political belief, or economic or social condition. We believe its attainment is essential for peace and security

It is becoming clear that the health sciences can contribute to man's ability to live harmoniously in a changing total environment. Thus, improved health enhances standards of living, promotes economic prosperity, contributes to our total objective, which is peace. The fundamental freedoms can be realized only when people are healthy and well nourished.

In the field of health, nations are interdependent Epidemics anywhere in the world are dangerous to other nations. Low standards of health lay a burden on prosperity and trade, im-

posing an economic handicap on every nation and on the world as a whole

The World Health Organization of the United Nations affords opportunity for an advanced kind of statesmanship heretofore too little utilized, but now encouraged and stimulated by the dramatic and pyrotechnic possibilities of atomic destruction if such statesmanship fails or is not utilized fully

Scientific Progress The enormous advances to be anticipated for medicine, the profound changes in industry, manufacture, home heating, air conditioning, are perhaps well, if only fragmentarily, illustrated in the following 3

The chain-reacting pile at Oak Ridge has used only five pounds of uranium in the production of atomic energy in nearly three years of operation, Dr W G Pollard, University of Tennessee physicist, declared today

Dr Pollard, a consulting scientist at the Government's atomic bomb plants, made the revelation at an atomic energy conference here sponsored by the University and Oak Ridge scientists

Comparing the production of energy chemically and through nuclear fission, Dr Pollard said the power plant at the university has required a ton of coal every two hours to keep it running, while one pound of lithium burned with hydrogen would keep it going for a year

In fact, there is a kind of furnace called a "pile" in operation now at Oak Ridge that produces just about the same amount of heat all the time as our university power plant does. That plant uses uranium as a fuel, though. It has been operating pretty nearly continuously for almost three years, now, and during that time it has consumed around five pounds of fuel.

Cities of the future will run their sanitary waste disposal systems as parts of their atomic energy power plants. Troublesome products now difficult to dispose of will become sources of desirable new materials for medical and household use

Homes, offices, factories, and streets will be illuminated by cold light, Dr Burton predicted Radioactive isotopes will bombard chemicals to produce intense light without much heat

New chemical processes for industry will result from the penetrating, high-energy radiation obtainable from atomic energy piles in large quan-

<sup>2</sup> New York, July 22, 1946

Address of Dr Milton Burton University of Notre Dame to the American Chemical Society, Sept 12, 1946 Dr Burton was formerly head of the radiation chemistry research in the atomic bomb development.

tities and at high intensities. Substances that usually cannot be made to combine will join together to form strange and useful products Dr Burton predicted

New drugs, new vaccines new radioactive dves are also forescen New kinds of plants and ani mals are other possibilities

The significance of chean and widely available energy to the advancement of human well being can only be fully realized by the kind of statesmanship which promotes the agreements of men until they prevail There is vet time

# Free Enterprise?

We have at hand a publicity release under the title "Plans Announced for Veterans" Hospital in Albany Expect to Complete Construction of 1,000 Bed Hospital by 1948"

It will be an eleven floor building, plus a separate utility building and residence building The construction will be under the direction of the New York District of the Corps

of Engineers.

Also according to the release, "Veteran patients will have a wide variety of services at their command, including a tailor shop, barber shop, billiard room, game rooms and libraries, a general canteen, including a soda fountain and restaurant, and a large auditorium in which motion pictures and other entertainment can be staged Another feature of the new hospital will be a limited number of guest rooms, reserved for patients' relatives who may want to visit the hospital and be close by without being bothered about hotel reservations '

The plan sounds wonderful We thought of what a contrast it presented to the old system of Soldiers' Homes, the equivalent aftermath of the Civil War We recalled the unsavory establishments that private enterprise caused to spring up about them. All the equivalents of the attractions listed above, plus the saloon We thought of the unsavory political connections necessary to the granting of such concessions. The concessionaires even used to provide attractive young girls who-no, no, please don't think that-were willing to marry the aging veterans. Of course the prospect of inheriting the husbands' pensions had no influence on the course of true love. If you don't believe this, inspect the records of the Pension Bureau What an advance over such con

ditions is presented by this new hospital presently to spring up at Albanyl

Then we thought of the restaurants, the cafeterias, the soda fountains, the news stands, the Coca Cola stands that we had gratefully patronized under the roofs of our most modern and progressive private hospitals We thought of the hotel accommodations—there can be no other name for them-offered to the anxious relatives of patients

But-and this is a very large but-all these luxuries were offered to us by private operators. Such proprietors, even if they be the hospitals themselves make their profits in competition with private enterprise because they operate under the roof of tax free institutions. Doubtless they are a great improvement over the nasty privately owned and operated enterprises that gath ered round the Soldiers' Homes like vultures round a corpse. But in principle they are nothing but extensions-or stretch ings, if you like-of the functions of the hospital that operates as a tax free, nonprofit institution. If we object to a hospital paying salaries to anesthetists, and thereby practicing medicine, why do we countenance hospitals going into the hotel, the amusement, and the restaurant business?

When the NEW YORK STATE JOURNAL OF MEDICINE is invited to insert an advertisement of an institution preparing to offer government competition with free enterprise, we think that the members of the State Medical Society might well do a little critical thinking about it Wedges being driven into the hull of the Ship of State, whether from the inside or the outside, whether from the purest or the most selfish motives, deserve careful scrutiny

# Current Editorial Comment

Metapon We have received from Dr Nathan B Eddy, a member of the Drug Addiction Committee of the Division of Medical Sciences of the National Research Council, a thorough account of and a recommendation respecting a new substitute for morphine, metapon hydrochloride. It is sponsored by the Committee on Drug Addiction of the Division of Medical Sciences of the National Research Council

It is recommended as possessing certain advantages which could make it the choice drug for treatment of the pam of cancer, especially in the home care of terminal cases, and for that purpose the Committee has recommended its manufacture and limited marketing

In terminal malignancy, administered orally, it gives adequate pain relief, with very little mental dulling, without nausea and vomiting, and with slow development of tolerance and dependence

It will be available only in capsule form for oral administration

Not only could we ill afford the space to explain just how metapon differs from morphine, but if we could it probably would be wasted space, for we don't believe our average reader would understand it any better than we

We are told that the drug is being manufactured by three firms and marketed by Its introduction to the medical profession is to be left in the hands of the National Research Council The careful, silent launching of this drug to the medical profession offers an agreeable contrast to the splashing debuts of others we can think To avoid the faintest implication of advertising, we simply state that any doctor interested in metapon, its chemical composition, what it does and doesn't do. who makes it, and from whom he can buy it need only write to Dr Nathan B Eddy, Committee on Drug Addiction, Division of Medical Sciences, National Research Council, 2101 Constitution Avenue, Washington 25, District of Columbia Readers' Digest and Paul deKruif, Ph D. may similarly inform themselves

The Public Education System For years the virtues of our system of public education

have been extolled by those who favored "state medicine" "Look," said they, "consider how well it works, how equitably for all It could be a model for a tax supported system of medical service Everybody would be better served Look at the noble school buildings, the excellent textbooks, the fine laboratories, the pension system, the compulsory education for everybody at everybody's expense"

Well, we have looked at it Certainly the plant and structure is good Textbooks are available. Athletic fields abound. Gymnasiums are provided. Sanitary facilities are of the best and usually well maintained. Bus service is available in rural and suburban areas generally. But what has happened to the teachers?

Daily we note that some are finding it necessary to take other jobs such as parttime bartending to supplement their miserable pittances as teachers, others are frankly quitting the profession

Public indifference to their reasonable requests for more equitable salary levels is in many instances discouraging superior talent from consideration of teaching as a profession and forcing out discouraged personnel who find it impossible to maintain a decent standard of living and their own self-respect at present salary levels

We hold no brief for commercialism in the professions. We have the greatest respect for the teaching profession. It has endured much, it deserves immediate rectification of gross salary inequalities before irreparable damage to its high quality and superior performance has been done.

We also take this occasion to point out again the inherent faults of government control and what inevitably happens thereunder where the professions are concerned. If the quality of teacher personnel and interest deteriorates, of what use are the buildings, the athletic fields, the good text-books, the noble plumbing fixtures?

Under, for instance, national health insurance schemes, would we not face the same discouraging factors? More important even than what government control can do for you, is what it can do to you

# Scientific Aiticles

### THE PRESENT STATUS OF BCG IN THE PROPHYLAXIS OF TUBERCULOSIS\*

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(From the New 1 ork Hospital and Department of Pediatrics Cornell University Medical College)

IN 1910 Calmette and Guérin announced that they had produced an attenuated strain of bovine tubercle bacilli capable of developing in cattle a marked degree of immunity against virulent tubercle organisms 1 During the eleven years that followed, numerous experiments on guinea pigs, rabbits, monkeys dogs, horses, and cattle proved this attenuated strain, the BCG bacillus, to be of definite protective value as well as incapable of returning to former virulence

In 1921 the vaccination of human infants was undertaken in France 2 and in 1924 the culture was offered for distribution to countries outside of France. Since that date over 5,000,000 chil dren have been inoculated throughout the world The majority of these vaccinations have been performed in various countries of Europe, Africa and Asia, although studies have been undertaken to a lesser degree in North and South America.

On the basis of these 5 000 000 inoculations, it can be stated that the vaccine properly prepared is entirely safe for human beings.

Numerous reports also have been published concerning the efficacy of the vaccine in the prophylams against tuberculosis The great majority of these reports are favorable but the actual degree of immunity conferred by the vaccine is still open to question.

In spite of this, wide publicity has been given the vaccine recently in medical journals, newspapers, and popular magazines. At the present moment plans have been completed already for its manufacture and distribution through certain centers in the United States. In the light of these developments it is important to study the experimental results of this inoculation and attempt to evaluate and summarize these results

The vast majority of the statistical reports on the efficacy of BCG unfortunately have been inadequately controlled A detailed report of most of these studies has been published already 3

Presented at the 141st Annual Meeting of the Medical Society of the State of New York, Buffalo General Sessions May, 7 1947

\* Alded by a grant from Meed Johnson and Company Evateville, Indiana.

In many of the studies controls were lacking completely in some the tuberculosis mortality rate of the general population was compared with that of the vaccinated group, in others a different age group served as a control, in certain stud ies the controls comprised cases where vaccina tion was refused in some there was a difference in age groups. In others the controls were less carefully followed than those vaccinated

More recently a paper has been published con cerning the results of BCG vaccination in Scandi navia. In all of the countries reported the results have been favorable, but again, the method of control selection appears inadequate.

In Oslo and in Bergen, Norway the tuberculosis mortality of the vaccinated group was compared with that of the general population In Stockholm, Sweden, where excellent results were reported by Wallgren, no controls were used. In answer to objections that no adequate controls were used, Wallgren stated that parents very seldom refuse to consent to BCG vaccination The studies in Norrbotten, Orebro, and Borans all in Sweden, were also controlled by the general population.

The vaccination also has been used extensively in Denmark, but controls are almost entirely lacking However, in spite of inadequate controls one cannot overlook the fact that with very few exceptions all the results have been uniformly favorable.

A number of reports have claimed efficacy for the vaccine on the basis of a reduction in pulmonary tuberculosis lesions on roentgenographic examination. This evidence is inadequate, since the vaccination acts as the primary focus of tu berculous and one should not expect to get the typical pulmonary complex on later exposure to tubercle bacilli From a roentgenographic point of view one should only judge the efficacy of BCG by its ability to prevent the caseous-pneu monic type of reinfection tuberculous.

Within the past year the greatest attention has been focused on three publications reporting ex perimental results with BCG inoculation in the United States These reports are "Experience with BCG Vaccine in the Control of Tuberculosis Among North American Indians," by Aronson and Palmer, "Ten Years Experience with BCG," by Rosenthal of the Tice Institute in Chicago, and "Results of BCG Immunization in New York City," by Levine and Sackett 3

The results obtained from the studies on Indians and those from the city of Chicago are favorable as to the value of BCG vaccine. The results in New York City are less favorable and statements concerning efficacy are guarded.

All three of these studies, however, are open to scientific criticism when viewed according to standards formulated as a result of the BCG research in New York City These standards set down as fundamental in the study of vaccine prophylaxis against tuberculosis are as follows

- 1 Vaccine must be of standard potency
- 2 There must be controls
- 3 Controls and vaccinated cases should
  - (a) Be selected by alternation to climinate possibility of bias
  - (b) Have identical follow-up
  - (c) Come from same locality
  - (d) Come from similar age group
  - (e) Come from similar racial group
- 4 Contact with cases must be maintained
- 5 Exposure conditions of cases must be known throughout the study period
- 6 A reliable diagnosis of the cause of death must be obtained

The results of the BCG study in New York City were extremely favorable prior to January 1, 1933 The mortality among the controls at that time was approximately five times as great as for the vaccinated cases (Table 1)

TABLE 1 —Results January 1 1933 Prior to Institution of Attenuate Selections

	Савез	Tuberculoris Number	Deaths Per Cent
Vaccinated Controls	445 545	3 18	0 08 3 38

Prior to January 1, 1933, the selection of cases for vaccination and controls was entirely at the discretion of the physician assigned to the case Under this system unintentional bias could easily enter into the selection, the tendency naturally being to vaccinate infants of the most cooperative families

Realizing this and on the advice of statisticians, the arbitrary division of cases was discontinued on January 1, 1933, and the method of alternate selection instituted. Under this method, alternate children were assigned for vaccination as soon as the names were received at the head-quarters and before they were given to staff pediaticians.

TABLE 2 —Comparative Results Before and After Alternate Selection

	Cases	Tuberculo Number	sis Deaths Per Cent
Total Cases BCG vaccinated Controls Cases December 15 1926, to January 1, 1933 (before alternate selec	1,011 1,073	11 26	1 08 2 42
tion) BCG vaccinated Controls Cases January 1, 1933, to January 1 ary 1 1944	445 545	3 18	0 68 3 38
(after alternate selection) BCG vaccinated Controls	566 528	8 8	1 41 1 51

The tuberculosis mortality results of this second period (January 1, 1933, to January 1, 1944) were essentially the same for both the vaccinated and control groups (Table 2)

Statistical analysis clearly demonstrated that the cooperation of the vaccinated group was appreciably greater than that of the control group prior to the period of alternation, with much closer approximation in the latter period. These results obtained in a carefully controlled experiment, nevertheless, are open to the following criticism.

According to published reports, the BCG culture used in this study became contaminated by molds late in 1932 necessitating considerable effort before pure cultures were once again obtained through the use of the antiformin method and plated on media containing aniline dyes Meanwhile subcultures were obtained from the Phipps Institute (which had received a strain of the New York Culture in 1926) These subcultures were used alternately for vaccine for one year, following which both cultures were used without selection Virulence tests were made at three-month intervals, but no tests were made for potency It is not beyond the limits of possibility that the original culture of vaccine was diminished in potency following the efforts to eradicate the molds

Ideally, a child should be separated from a tuberculous focus for three months before the prevaccination tuberculin test to prevent moculation during the preallergic phase of tuberculosis. On the other hand, the child should be separated for from six weeks to three months following the vaccination in order to permit the formation of adequate immunity before exposure to virulent human tubercle bacilli. Such a procedure was found impossible for general adoption in New York City

However, in a limited number of cases where such separation was possible, there was some in-

TABLE 3 -- Exposed Cases Separated Three Months Before and Three Months After Being Vaccinated on Taken Up

	Самея	Tuberculo Number	els Deaths Per Cent	
\ accinated Controls	91 96	1* 3†	1 1 3 I	Arison Pro
* This child	was been of a	mother dring f	tuberculouis	Pim

\* This child was born of a mother dying I tuberculosis was never exposed died at three mouths of age † One case with no known exposure died of tuberculosis at 15 months of age.

dication that BCG inoculation had protective value (Table 3)

The studies on Indians' were undertaken at eight different reservations in Vestern United States and in Alaska Approximately equal numbers of Indians were selected for vaccunation and controls. The results are reported in Table 4.

In these studies cases were not alternated and in writing of the method of selection it is stated that "its, of course, not possible to be certain that no bias was unintentionally introduced"

Furthermore, in the Indian experiment, the diagnosis at death is open to question since it is published that "in the control group some of the deaths which were assigned to nontuberculous causes actually may have been a consequence of tuberculosis." The New York studies clearly demonstrated the necessity of postmortem examinations for accurate diagnosis.

Also in these studies on American Indians several methods of cultivating the vaccine were used, and in explaining a discrepancy in results at one of the reservations it is stated that "these relatively poor results may be attributed, perhaps to the fact that the three lots of vaccine used on this reservation were prepared from a slow growing culture and probably contained many dead organisms"

The arbitrary rating of exposure is also open to criticism as is the lack of separation from contact cases. However, the results of these studies clearly are favorable and must be added to the long list of such reports.

The report of ten years experience with BCC in the city of Chicago also is favorable. This is a well-controlled study in which alternation was used and in which cases were separated before and after vaccination and controls separated in similar manner. However, in this study the exposure to tuberculosis frequently is unknown after vaccination, and a considerable number of the children have been lost. No information has been published in this study concerning the racial proportion among the vaccinated and control groups although of the ten tuberculous deaths as of April 1940, seven were of negro children. But, again the results are definitely favorable.

Within the past few years the opinion has be-

TABLE 4 —RESULTS OF BCG STUDIES ON INDIAN RESERVA

\ soci- nated Cases	Tuber culcula Douths	Con trols	Tuber eulosis Desthi
250	1	63	•
0.5	ō	88	
	-		
110	0	8.5	1
118	ĭ	106	ã
	-		-
170	0	162	0
41	ő	2.5	ĭ
	•		-
260		.60	0
497	ō	464	1
	250 95 110 118 170 41	nated   culcula   Cases   Deaths	rated culcula Con- Caser Deaths trois  250 1 03 85  110 0 85 1115 1 105  170 0 102 25 260

come more and more accepted that the response to a primary tuberculous complex in the young adult is much more sovere than the response in infancy and childhood, that in young adults the primary infection may, at times progress rapidly into the severe and dangerous caseous-pneu monie type

If this opinion is correct then the inoculation with BCG of tuberculin negative preadelescent children should be of the greatest benefit since it provides the body with an inocuous primary complex and through this, a protection against the primary tuberculous inflammation of the lungs from exogenous sources

Since the recent publicity, numerous inquiries have been made concerning the vaccine. What people may be vaccinated? What degree of effectiveness is claimed for the vaccine? How long does the vaccination remain effective? How is the vaccine administered? What reaction follows vaccination? Can the vaccine be obtained for use in general practice?

In the first place it must be emphasized that the vaccine is used only for prophylaxis against tuberculosis and not for treatment of the disease. Use of the vaccine is limited to individuals with negative tuberculin tests

The actual degree of immunity conferred by the vaccine is not known at the present time. However judging from the results of even the most favorable reports one would conclude that immunity is not complete, as it is with smallpox diphtheria or typhoid inoculations. Although a certain degree of immunity is indicated a number of tuberculous deaths may still be expected among vaccinated persons.

The duration of the immunity following vaccination is also not determined although many authors believe that immunity remains as long as the tuberculin test resulting from the vaccina tion remains positive. Others, however contend that the tuberculin sensitivity and immunity are not related and that immunity persists in spite of the loss of tuberculin sensitivity

It is now felt generally that a potent culture of

BCG vaccine properly administered should cause the development of a positive tuberculin reaction in a very high percentage of the cases, but, again, results vary considerably

In the Chicago study the tuberculin test following BCG inoculation became positive in 99 62 per cent of the cases. At the end of fifty-five to sixty months the tuberculin test was still positive in 70 09 per cent of the children. Overton in Nashville, Tennessee, reported the development of tuberculin allergy in 100 per cent of 4,679 subjects <sup>8</sup>

The paper on the American Indian study reports only 56 per cent positive tuberculin reactions to the stronger dilution of a purified protein derivative (0 005 mg) one year after vaccination. The New York study reported 86 per cent tuberculin positive one year after vaccination.

This discrepancy in findings may be due to the amount and potency of the vaccine used, the method of inoculation, the manner of tuberculin testing, differences in racial groups tested, or the opportunities for contact with human tubercle bacilli

In public health projects it seems advisable that vaccinated persons be tuberculin-tested two months after vaccination to determine that the vaccination has taken, and retested every two years thereafter Tuberculin-negative persons should be revaccinated

Certain other important information concerning the reported efficacy of the BCG vaccine is still lacking. Among these are the effectiveness of the vaccine under varying degrees of exposure, the effectiveness of the vaccine in different age and racial groups, with various degrees of resistance, the effectiveness of the vaccine when prepared with different culture media.

The vaccine is administered in one of three manners the multiple puncture method, the scratch, and the intradermal method. A local lesion follows, which at the most leaves a scar resembling that of vaccination against smallpox. In a certain number of instances of intracutaneous inoculation, suppuration of the lymph nodes draining the area may result. This subsides in a few weeks. No fever is associated with the vaccination and no pain or disability.

It would seem that until further knowledge is obtained concerning BCG that it still be given in a semiexperimental manner, and that its distribution be limited to medical colleges, public tuberculosis hospitals and clinics, and to selected additional hospitals and institutions under the supervision of trained personnel.

The vaccine should be recommended for experimental use where there has been a known exposure to tuberculosis or where exposure is likely to occur, in groups occupationally exposed, such as nurses and medical students, and in selected population groups with high tuberculosis morbidity and mortality rates

In these studies it is important that eareful records be made and filed for further analysis, and that there be adequate opportunity to follow both controls and vaccinated patients over a period of years

# Summary

- 1 On the basis of over 5,000,000 BCG inoculations on human beings throughout the world, it can be stated that the vaccine properly prepared is entirely safe for human beings
- 2 Numerous favorable reports have been published on the efficacy of the vaccine but with very few exceptions these studies have been poorly controlled
- 3 The many favorable reports, though not conclusive, would seem to indicate that the BCG vaccine may be effective in the prophylaxis against tuberculosis
- 4 In view of these numerous, favorable reports and in view of plans for distribution of the vaccine in the United States, it is important that our present knowledge concerning the vaccine be further evaluated
- 5 Further knowledge is needed concerning (a) the actual degree of immunity conferred by the vaccine, which is not known at the present time, (b) the duration of immunity following BCG moculation which also has not been determined, (c) the effectiveness of the vaccine under varying degrees of exposure, (d) the effectiveness of the vaccine in different racial groups with various degrees of resistance, (e) the effectiveness of the vaccine when given to various age groups, and (f) the effectiveness of the vaccine when prepared with different culture media
- 6 It is to be advised that until this further knowledge is obtained, the vaccine be distributed and used in a semiexperimental manner

1111 PARK AVENUE

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# THE PHARMACOLOGY, PHYSIOLOGY, AND CLINICAL EVALUATION OF THE NEW ANTIHISTAMINIC DRUGS (PYRIBENZAMINE AND BENADRYL)

CARL E ARBEMIAN, M.D., Buffalo, New York

(From the Buffalo General Hospital and Buffalo Children's Hospital University of Buffalo, School of Medicine)

THE development and clinical use of potent antihistaminic and antianaphylactic drugs in the treatment of allergic diseases is probably the greatest advance in the therapeusis of allergy since the discovery of epinephrine in 1901

Since Dale and Laidlaw<sup>1</sup> in 1910 pointed out the close resemblance between histamine shock and anaphylactic shock in guinea pigs, and Lewis <sup>1</sup> in 1927, postulated that a histamine-like substance, which he designated as H substance, was liberated by the tissues of humans at the site of the allergic reaction, attempts have been made to find some nonspecific substance which would inhibit all anaphylactic and allergic reactions, no matter what the antigen happened to be

In recent years, further evidence has been accumulated to support the histamine theory of al largic manifestations Dragstedt' and Code' have ably reviewed the literature on this subject. Suffice it to say, enough data have been obtained to use this theory as a working hypothesis to explain the mechanism of an allergic reaction The theory is illustrated in a somewhat simplified form in Fig. 1 This scheme presents various avenues of therapeusis for allergic conditions in man. The primary and foremost method would be to prevent the antigen-antibody reaction by eliminating the offending allergen where possible -such as a food or net which causes the symptoms. The patient with ragweed hay fever could move to a ragweed free area but this is not always practical In many instances, it is obviously im possible to eliminate these factors.

When the allergen cannot be removed, another method, called specific hyposensutiration, preventing this antigen-antibody reaction can be employed. A thermostabile or "blocking" antibody is produced by injecting small, increasing doses of the offending allergen into the patient. This new antibody then reacts with the allergen and prevents it from reaching the antibody at the abock organ

A third approach to the treatment of the al lergic reaction would be aimed at altering the action of the end product of this allergen-anti body reaction, namely, histamine This might be achieved by means of one or more of the possible methods proposed by Dragstedt.<sup>3</sup> They may be outlined as follows

1 By opposing the pharmacologic action of histamine through stimulation of the sympathominetic system (epinephrine)

2 By direct action (relaxation of bronchial

musculature)

3 By preventing the release of histomine

4. By direct chemical combination with neutralization of histamine introduced or liberated at the site of action

5 By blocking the action of histamine

As early as 1932 Hill and Martin' listed 105 substances or methods which had been used to attempt to inhibit anaphylans. Some of the substances listed were ether, atropine, banum, chloral, and benzene in large doses. However most of these were either too toxic or impractical to use clinically

Within the past decade the amino acids—arginine, histidine, and cysteine—were shown to have antianaphylactic and antihistamine properties. Histamine histamines, and histamine axoprotein have been studied thoroughly and reported to be antihistaminic and antianaphylactic. All of these substances have been used clinically, but the results obtained with them have been disappointing

In 1937 Bovet and Staub studied a group of chemical compounds and found two which had marked antihistaminic and antianaphylactic properties. These substances thymoxyethyldiethylamino and N'-phenyl N-ethyl N'-diethyl ethylenediamine, were designated 929F and 1571F, respectively (The chemical formulas of these drugs and the ones to be described below are shown in Fig 2) These compounds how ever, were too toxic to use clinically

Halpern, in 1942 described his observations with two new compounds. One of these, N'-dimethylamine ethyl N'-bensylaniline (also known as 2339RP and antergan), was investigated by many European workers \*-12 This drug was found to be more effective and less toxic than 929F or 1571F, and hence, was used clinically in the treatment of various allergic conditions. Promising results were reported.

More recently Bovet and associates described a new drug N P methoxybonsyl-N-dimethyl-

Presented at the 141st Annual Meeting of the Medical Society of the State of New York Buffalo General Socious, May 7 1947

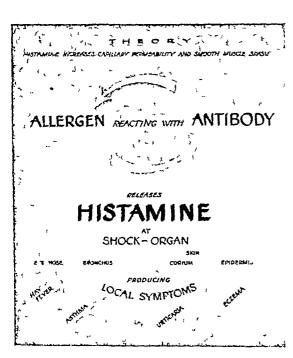


Fig 1 Schematic interpretation of the histamine theory

2-Isopropyl 5-methylphenoxyethyldiethylamine ethyldiethylamine or compound 929F) (thymoxy

$$\begin{array}{c|c} & & & \\ & & & \\ & & & \\ & & & \\ & & & \\ & & & \\ & & & \\ & & & \\ & & & \\ & & & \\ & & & \\ & & & \\ & & & \\ & & & \\ & & \\ & & & \\ & &$$

N' Phenyl N ethyl V diethylethylenediamine or compound 1571F)

N'-Phenyl-N'-ethyl N-dimethylethylenediamine (dimethyl aminoethylaniline or compound 2325RP)

N'-Phenyl-N'-benzyl N-dimethylethylenediamine (dimethylaminoethylbenzylamine Antergan or compound 2339RP)

N-P-Methoxybensyl-N-dimethylaminoethyl  $\alpha$  aminopyndine (Neoantergan or compound 2786RP)

Pyribenzamine (N'-pyridyl-N' benzyl N dimethylethylenediamine)

$$\begin{array}{c|cccccccccccccccccccclc} & & & & & & & & \\ & & & & & & & & & \\ & & & & & & & & \\ & & & & & & & & \\ & & & & & & & & \\ & & & & & & & & \\ & & & & & & & & \\ & & & & & & & \\ & & & & & & & \\ & & & & & & & \\ & & & & & & & \\ & & & & & & \\ & & & & & & \\ & & & & & & \\ & & & & & & \\ & & & & & & \\ & & & & & & \\ & & & & & & \\ & & & & & & \\ & & & & & & \\ & & & & & & \\ & & & & & & \\ & & & & & \\ & & & & & \\ & & & & & \\ & & & & & \\ & & & & & \\ & & & & \\ & & & & \\ & & & & \\ & & & & \\ & & & & \\ & & & & \\ & & & \\ & & & & \\ & & & \\ & & & \\ & & & \\ & & & \\ & & & \\ & & & \\ & & & \\ & & & \\ & & & \\ & & & \\ & & & \\ & & \\ & & & \\ & & \\ & & & \\ & \\ &$$

Beta dimethylaminoethyl benzollydr\(\frac{1}{3}\) cther hydrochloride (benadryl hydrochloride)

Synthetic histaminics 3015 and 3277

Fig 2 Chemical formulas of the various antihistamime drugs which have been used clinically and experimentally

ammosthyl and aminopyridine (neoantergan or compound 2786RP) <sup>12</sup> This drug is claimed to be more potent and less towe than antergan Bernstein, Rose, and Feinberg<sup>14</sup> found neoantergan to be quite effective clinically

In the past few years intensive research has been underway in this country in an attempt to find more effective and less toxic compounds with antihistaminic and antianaphylactic activity Two such drugs have been investigated thoroughly both clinically and experimentally, by many workers, and are now available for clinical use They are N' pyridyl N' benzyl N-dimethyl ethylenediamine (pyribenzamine, Ciba) and beta-dimethylaminocthyl benzohydryl ether hy drochloride (benadryl, Parke-Dayis) drugs are very similar in action. The present report will describe our clinical and experimental experiences with pyribenraming since November. 1944, and compare our results to those of other workers using either pyribenzamine or benadryl

The exact mode of action of these substances is not known. Mayer postulates from his work that these compounds compete with histamine at a given sate of action or receptive substance. This so-called displacement theory has been thought to account for other types of antagonism such as the atropine acetylcholine system, and the para aminobenoic acid, sulfonamide system

The phamacologic properties of pyribenzumine are described by Yonkman <sup>14</sup> He says that pyr benzamine counternets histamine-induced 'asthma in guinea pigs, contraction of bronchi in dog, hypotension in the dog, contraction of intact dog intestine, and salivation in the cat. It also counteracts anaphylactic shock in the guinea pig construction of the bronchi in perfused lung of guinea pig, hypotension in the dog and construction of the intestine in the dog. Other actions include analepsis local anesthesia, and adrenergic potentiation

Following the administration of pyribensamine Mayer was able to protect guinea pigs from histamine and anaphylactic shock. Arbesman, et al., demonstrated this same action using passively sensitized guinea pigs 18 Feinberg and Friedlander showed that pyribensamine was six times as effective as beindryl in protecting guinea pigs from histamine shock and about equally as effective against anaphylaxis. It was also shown that pyribenzamine had no effect on precipitin or complement fixation reaction titers 19

Most investigators found no change in the acid concentration of the stomach after histamine, if it were given after the administration of either of the two antihistamine drugs \*11 Furthermore,

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no noticeable changes in blood prossures, blood chemistry, cell counts, liver, and kidney function tests were noted in either humans or dogs, fol lowed over a period of twelve months <sup>12</sup> Curry recently has shown that the diminished vital capacity asthmatic patients develop following histamine injections is prevented by both infravenous benadryl and to a lesser extent by oral puribenzamine <sup>23</sup> Arbesman, et al., have fur their shown that pyribenzamine decreases the size of lustamine wheals allergic wheals, and passive transfer wheals <sup>13</sup> This work has been confirmed by Funberg and Friedlander <sup>23</sup>

#### Clinical Experiences

Dosage and Tolerance -The effective dosage of pyribengamine and benadryl was found to vary greatly from individual to individual also varied in the same patient at different times depending upon his allergic state and the degree of exposure to the offending allergens average adult dose for pyribenzamine varied from 100 to 400 mg daily and the dose for children from 50 to 200 mg At times, as much as 1,200 mg of pyribenzamine was given to adults in a twenty four hour period without any untoward effects It has been our experience that children tolerate this drug very well Benadryl dosage in adults varied also from 100 to 400 mg daily children 40 to 80 mg of benadryl was prescribed Both pyribengamine and benadryl are given orally and usually in four daily doses, after meals Benadryl may be given intravenously if necessary Pyribenzamine often produced relief of symptoms within fifteen to twenty minutes The duration of the effect of this drug showed con siderable variation. Some patients reported rehef lasting as long as eight to twelve hours, whereas others had relief of only one to three hours

E Seasonal Allergic Rhamits—During the pollen seasons of 1945 and 1946, we treated 288 patients who had allergic rhinitis caused by the grass or ragweed pollens with pyribensamine Table 1) Of this group 244 or 84.6 per cent, had relief of symptoms There was less sneezing rhinorthea, and itching eyes, but the nasal occlusion was not allevanted as much. The reports in the literature reveal 52 to 82 per cent or an average of 70 per cent improvement with pyribenzamine, \*\*\* and 10 to 80 per cent, or an average of 68 per cent with benadry! \*\*1-28

TABLE 1 -SEASONAL ALLERGIC REINITIS

Treated with	Number of	Percentage Improved
	CHICA	Timber 4ct
Pyribensamine Pyribensamine (hterature)	288	84 6
vribensamine (literature)	1 728	70 8
tenadryl (literature)		68-0

TABLE 2—Effect of Pyribentamine on Seasonal Bronchial Astrina

Type of Case	Number of Cases	Improved	Percentage Improved
Asthma with allergio rhimitis Asthma alone	48 13	21 7	43 0 53 0
Total	61	28	46 0
TOTAL			

5 Seasonal Bronchial Asthma—Forty-eight of the 288 patients with hay fever also had bronchial asthma due to the pollens—Thirty-eight of these 48 patients had relief of nasal symptoms when given pyribenzamine but only 21 had relief of both nasal and bronchial symptoms (Table 2) Thirteen additional patients who complained of bronchial symptoms but no rhinitis were studied Seven of these were relieved—Hence, of a total of 61 patients suffering from pollen bronchial asthma, twenty-eight had relief of symptoms when given pyribenzamine

4 Perennial Allergic Rhinitis - One hundred and forty-four patients with perennial allergic rhinitis of extrinsic origin were treated with pyribenzamme (Table 3) One hundred and seven (74 per cent) of them had relief of symptoms In addition, there were 29 patients with intrinsic allergic rhinitis (negative skin tests), who were also given pyribenzamine Eleven (37 per cent) of these 29 patients had improvement in symptoms from the drug The reports in the literature reveal 47 to 64 per cent, or an average of 56 per cent improvement with pyribenzamine24-34 and 15 to 74 per cent, or an average of 41 per cent with benadryl 31-34

TABLE 3 -PERENNIAL ALLERGIC RHINITIS

Drug	Number of	Number	Percentage
	Cases	Improved	Improved
Pyribenzamine Extrinsic Intrinsic Total	144	107	74
	29	11	37
	178	118	68
Pyribensamine (literature) Benadryl (litera-			56
ture)			41

of 173 patients with allergic rhinitis, 67 of them had concomitant bronchial asthma (Table 4) Although 45 of these 67 noted improvement of nasal symptoms following pyribenzamine, only 31 had relief of the bronchial symptoms as well Thirty-two additional patients with bronchial asthma without nasal symptoms also were given pyribenzamine orally. Of this group fifteen patients claimed beneficial results from this compound. Hence, of a total of 99 patients with bronchial asthma, 46 per cent were helped by

TABLE 4.—PERENNIAL BRONCHIAL ASTHMA

	Number of	Number	Percentage
Drug	Cases	Improved	Improved
Pyribenzamine Asthma with allergic rhi-			·
nitis	67 82	31	46
Aathma alone	82	15	46
Total Pyribenzamine	99	46	46
(literature) Benadryl (litera-			23
ture)			43

pyribenzamine The reports in the literature reveal 6 to 35 per cent, or an average of 23 per cent improvement with pyribenzamine<sup>26-20</sup> and 10 to 65 per cent, or an average of 43 per cent with benadryl <sup>21-38</sup> (Table 4)

# The Effect of Pyribenzamine on Urticaria

Eighty-four patients with acute urticaria were treated with pyribenzamine and 79 were benefited. Of this group, 24 patients had postpenicillin urticaria and arthralgia. Twenty-three of these 24 patients whose lesions appeared anywhere from three days to three weeks following the cessation of penicillin therapy had dramatic relief of symptoms (Table 5).

TABLE 5 -URTICARIA

Effect of Pyri- benzamine On	Number of Cases	Number Improved	Percentage Improved
Acute urticaria Chronic urticaria Total Pyribenzamine	8 <u>4</u> 115 199	79 78 157	04 68 78
(literature) Benadryi (litera-			78 6
ture)			79 S

One hundred and fifteen patients had chronic urticaria, dermatographism and/or angioneurotic edema. Of the group, 68 per cent had alleviation of pruritus and decrease in size of wheals, swelling, and erythema following pyribenzamine therapy. The reports in the literature reveal 60 to 96 per cent, or an average of 78 6 per cent improvement with pyribenzamine 25-30 and 61 to 100 per cent, or an average of 79 8 per cent with benadryl 21-38

# The Effect of Pyribenzamine on Miscellaneous Conditions

Several other conditions were treated with pyribenzamine (Table 6) Inasmuch as a marked antipruritic effect was noted in the treatment of urticaria with these drugs, they were prescribed for various dermatoses. Fifty-seven per cent of 21 patients with atopic eczema and 4 of 7 patients with infantile eczema had definite relief of itching. However, in dermatitis venenata, only 6 of 20 patients benefited from these substances. Pruritus am and vulvae was relieved in

TABLE 6 -- MISCELLANEOUS CONDITIONS TREATED WITH PRESENTAMENE

		Number of Patients	Number Improved
1	Atopic ecsema	21	12
ż	Infantile eczema	-7	7
•	Dermatitis venenata	90	Ġ
7	Pruritus	U	•
٠.			
	(s) Unknown etiology	11	5
	(b) Aniand vulvae	•	3
	(c) Jaundice	3	a a
	(d) Dermatitis herpetiformia	1	1
	(e) Insect bites	2	3
ð	Reborrhela dermatitia	1	a
6	Acna rosaces	2	0
7	Migraine	5	í
Š.	Histamine cephalgia	ā	ñ
ŭ	Aleniere a syndrome	- 7	ň
10	Allerric headaches		ĭ
iĭ	Visitale normanie	•	
:1	Gastrointestinal allergy		4
12	Genitourinary allergy	į.	ō
13	Allergic conjunctivitie	4	1

TABLE 7 -SIDE-EFFECTS OF PYRIBENSARINE

Total number of side-effects -- 374 \* Had to stop drug.

3 of 4 patients as were 2 of 3 patients relieved of itching from saundice.

The treatment of migraine, histamine cephal ga, Meniere's syndrome, and allergic headaches with pyribensamine was very discouraging Only 2 patients of the entire group of 12 patients received any beneficial effects. The same type of experience, for the most part, is reported in the literature for both pyribensamine and benadry! However, 2 patients with gastrointestinal allergy were improved with pyribensamine, while no effect was observed in 2 others with the same con dition.

#### Comment

Sub-Reactions —As noted in Table 7 72 7 per cent of the 800 patients treated with pyriben namine had no untoward effects. A total of 44 patients or 5.5 per cent, had to stop the drug because of the severity of the sub-effects. There were 218 patients who had a total of 374 untoward restrous. The most frequent side-effects en countered from this drug were drowsiness, nausea, headache, fatigue, and dissiness. All of these various side-effects, their relative frequency, and incidence are listed in Table 8

It is interesting to note that patients receiving large doses of pyribensamine had aide-reactions more frequently than the patients receiving small or moderate doses. In many instances these untoward reactions could be circumvented by decreasing to a smaller but still effective dose. There was also a rather marked difference in individual tolerance to pyribensamine. Several patients were able to tolerate as much as 1,200 mg.

TABLE 8 -Side Reactions (800 Patients to March 1 1047)

1 2 3 4 5 6 7 8 9	Drowsiness	73 60
3	Nausea	60
3	Headache	33 33
•	Patigue	
	Dissinger	18
2	Inoreazed allergio resutions Diarrhos	18
- 6	Dryness of mouth	13
8	Palpitation	15 13 14
10	Abdominal cramps	i -
11	Emesis	îa
11 12	Jitterinees	- <del>7</del>
13	Faintness	4
14	Parenthesias	ī
15	Light headedness	4
16	Weakness	đ
17 18.	Nervousness	4
18.	Perspiration	4
19	Insomnia	2
20	Feverishness	8
21 22 23	Anorezia	Q
22	Thirst	2
23	Heartburn	3
24	Increase of mensee	13 7 4 1 1 4 0 4 4 4 2 2 8 0 2 2 2 2 2 2 3 2 2 3
25	Impotence	,
26 27	Urinary (polydypnia—polyures)	:
37	Decreased force of urinary flow	-

daily without ill effects, whereas, in a few others as little as 25 mg produced undestrable reactions. Many patients having symptoms of drownness upon first taking pyribenzamine were able to tolerate it without reaction after continued usage

Teinberg in his review on antihistaminic substances stated that about 50 per cent of the patients taking benedryl had some untoward reactions, whereas between 25 to 30 per cent of the patients receiving pyribenamine complained of some side-effects. The most disturbing side-effect of boundryl is marked drownness whereas the most annoying ill effects from pyribenamine are gastrointestinal complaints, i.e., nausea, emesis or diarrhea.

One of the reasons for the increased effectiveness of pyribenzamine as compared to benndry may be that larger doses of pyribenzamine can be given without as many side-effects. However in many instances patients who could not tolerate one drug could take the other with benefit. In addition to this, benndryl might be more effective in a certain patient, whereas pyribenzamine might be more effective in another. At times the seds tive action of beandryl is desirable and I have often given patients pyribenzamine during the day and beandryl at bedtime.

#### General Effects of Pyribenzamine in Allergic Patients

There is no doubt that the antihistaminic drugs relieve the symptoms of lacrimation rhinorrhea, and sneezing in allergic rhinitis. The nasal blooking, which is often associated with this condition, is not too readily alleviated. Likewise, when there is a superimposed infection on an allergic rhinitis, pyribenamine and benadryl are less effective. At times large doses of these

TABLE 9 -- RAGWEED STUDIES, PRIVATE PRACTICE

	Num- ber of Cases	Im- proved	Less than 50 Per Cent Improve- ment	Percentage Improved 50 Per Cent plus
Adequate hy- posensitisation	242	106	136	44

Effect of Adding Pyribenzamine to 136 Cases of Ragweed Pollinosis in Which There Was Unsatisfactory Response from Adequate Hyposensitization Alone

		Number of Cases	Improved	Percentage Improved
Hay fever toms Bronchial toms	symp-	184	123	91
	By Intr-	39	24	61

drugs are necessary to control symptoms This is usally the case when the pollen counts are highest. With the increased dosage there is an associated increased percentage of side-effects

In a recent study we compared the efficacy of pyribenzamine alone with specific hyposensitization therapy plus pyribenzamine when necessary in the treatment of ragweed hay fever (Table 9) "Sixty-seven per cent of the patients receiving pyribenzamine alone were helped, but with specific hyposensitization therapy and pyribenzamine when needed, 91 per cent received relief of symptoms. In this latter group much smaller and less frequent doses of pyribenzamine were necessary to control symptoms, and the incidence of side-effects int his group was negligible

When bronchial asthma is associated with allergic rhinitis, in most instances the bronchial symptoms are not relieved In 8 such patients. although the allergic rhinitis was alleviated. the bronchial symptoms were aggravated a smaller percentage of cases, we have noted that pyribenzamine produces some bronchial relaxing effect in asthma This is more evident prophylactically than therapeutically benzamine is given one-half to one hour prior to exposure to an offending allergen which ordinarily produces asthma, the symptoms are usually pre-However, once the symptoms of bronchial asthma have developed, the degree of relief obtained by oral pyribenzamine is not nearly as dramatic as that of epinephrine or aminophylline However, we have shown that there is a definite synergism between pyribenzamine and ephedrine, and/or aminophylline 45 When both of these drugs are given together, the effect on the symptoms is greater in intensity and duration than if either drug were used alone

Mayer 16 recently demonstrated that a 2 per cent aerosol spray of pyribenzamine prevented histamine shock in guinea pigs. In the past few months we have used a 2 per cent pyribenzamine saline solution as an aerosol spray in the treatment of acute paroxysms of asthma. A De-

Vilbiss number 40 nebulizer was used and the patient instructed as to its use. Two cc of solution was placed in the nebulizer and the patient was advised to inhale until relief of symptoms was obtained. Although the number of patients so treated is small, the results look very promising. Of 12 patients with true extrinsic bronchial asthma, 7 obtained instant and dramatic relief of the acute paroxysm. Its effectiveness seems equal to, or superior to, epinephrine 1–100. The only side-effect noted has been dryness of the mouth However, we used this same method of therapy in intrinsic asthmatics and extrinsic asthmatics with infection, and no benefit was noted.

We have also noted and reported that pyribenzamine can prevent constitutional reactions in patients receiving injection therapy <sup>47</sup> Allergic reactions to injections of liver extract and insulin frequently can be prevented by the prophylactic administration of pyribenzamine. Urticaria due to cold or sunlight is prevented by the use of these drugs prior to exposure. These histamine antagonists do relieve the itching of the skin and reduce the wheals and erythema in urticaria to a marked degree.

The remarkable and sometimes surprising results obtained with these drugs are only palliative As soon as the medication is stopped, there is a recurrence of symptoms These substances probably do not immunize the patient or protect him from the effects of an allergic reaction for any prolonged period Therefore, it is important for the allergic individual to continue with his allergic The causative agent should be determined when possible and specific hyposensitization therapy instituted We have shown that one obtains the best results with combined allergio therapy and the histamine antagonists when indicated 44 In many instances it is often impossible to find the etiologic agents of an allergic reaction and it is here that these new substances have their greatest value

The good results from antihistaminic substances in allergic conditions, particularly of the true atopic, wheal-like reaction, such as urticana, extrinsic rhinitis, and physical allergies, indicate that histamine must play some definite role in an allergic reaction It is the general consensus of opinion among investigators that histamine is not the only factor in allergy or anaphylaxis This may account for the lack of response in all types of allergic disorders It may be due to this fact, or that not enough histamine antagonist reaches the site of the allergic reaction, that so many failures in bronchial asthma occur ever, our recent experience with nerosol pyribenzamine indicates that very small amounts of the drug administered directly to the site of action, the tracheobronchial tree, can relieve in-

TABLE 10 -SUMMARY EFFECT OF PUBLISHMENT

	Number of	Number Improved	Percentage Improved
Allergie rhinitis (all types) Bronchial sathma Urticaria	461 150 199	362 76 157	78 5 47 0 78 0

stantly an acute paroxysm of asthma Thus would tend to substantiate the theory that the antihistaminic drugs work on a competitive basis with histamine at the end organs The failures obtained with these substances in intrinsic asthma would indicate that some other mechanism besides historine accounts for the symptoms

The present antihistaminic drugs available are by no means ideal. The side-reactions are too frequent and the results obtained in all allergic disorders could be better Intensive investiga tions are now in progress attempting to find more effective and less toxic histamine antag onists. Neoantergan which has just recently been introduced in this country seems to be a drug worth watching Halpern and associates have just reported two other compounds (Fig 2) which are five to ten times as potent as neoantergan and not as toxic. \* Eventually a substance long sought by investigators in the field of allergy and anaphylaxis which prevents all types of allergic reaction no matter what the allergen or the manifestation may be discovered

## Summary and Conclusion

- Pyribenzamine has been used since November, 1944, in 800 patients with various allergic disorders (Table 10)
- Pyribenzamine relieved 78 5 per cent of 461 patients with allergic rhimits of all types.
- Pyribenzamine relieved 47 per cent of 159 patients with bronchial asthma.
- Pyribenzamine relieved 78 per cent of 199 patients with urticaria.
- No serious side-effects have been noted in any patients Many patients have received this drug daily for over two years with no effects on the blood morphology, blood chemistry, urine liver, or kidney function tests
- 6 From our own experience and the information reported in the literature, it appears that pyribenzamine is more effective and less toxic than benndryl.
- Antihistaminic drugs are palliative, and if permanent relief is to be obtained, the etiologic factors of allergic manifestations must still be determined and climinated

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# PUBLIC HEALTH ASPECTS OF THE TREATMENT OF TINEA CAPITIS

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THERE is an epidemic of tinea capitis in the United States—It was first brought to the attention of the US—Public Health Service about four years ago by reports from New York, Philadelphia, and Pittsburgh, but it has now spread to practically all parts of the country

Tinea capitis may be caused by various types of fung, such as trichophyton gypseum, microsporon felineum, microsporon fulvum, micro-The present epidemic is sporon audoum, etc due mainly to microsporon audoum disease usually affects children and usually disappears spontaneously after puberty, due to the increase of pelargonic acid in secretions of skin after puberty When the fungi from animal sources cause the disease in humans, there is present on the scalp a marked inflammatory response, which usually results in a cure, but when the cause is the microsporon audouini there is but little, if any, inflammatory response and the disease persists

The city of Hagerstown, Maryland, in 1944 requested the assistance of the Public Health Service in controlling an epidemic which was present there. Hagerstown has a population of about 40,000. There were about 7,000 children in the grade schools and examination of them with the Wood's light revealed about 600 cases of tinea capitis. Microscopic and cultural examinations showed that 98 per cent of the cases were caused by microsporon audouin

Careful examinations and investigations showed that barber shops were the principal sources for spreading the infection and that the electric clippers were mostly responsible Proofs of this were the finding of infected hairs in the clippers, the fact that there were six times as many boys infected as girls, that all the boys had infection in the clipper areas of the scalp. that 65 per cent of the affected boys had the infection only in the clipper areas and that most of the girls were affected only in the hair parts Other lesser sources of infection were found to be common combs and brushes in the homes, the custom of exchanging caps in the schools, and the plush and mohair backs of motion picture seats

The manufacture of electric clippers was stopped during the war This created a shortage so that in some shops one pair of chippers served This did not permit the thorseveral barbers ough cleaning and sterilization of the clippers after each use Besides, the methods of sterilization found in the barbér shops were inadequate to kill fungi In order to remedy these conditions experimental work was done on killing fungi in It was found that immersing the the clippers clippers in mineral oil having a boiling point of 200 C, kept at a constant temperature of 100 C would sterlize them in one minute result could be obtained by immersing the clippers in 2 per cent of boiling lysol for three minutes or in 10 per cent cold lysol for fifteen minutes

As a result of meetings with the city governing authorities, the school authorities, state and city health officials, parent-teacher associations, barbers' associations, and local medical societies, it was decided that the control of the epidemic be placed in charge of the Public Health Service which detailed two full-time dermatologists to Hagerstown for this purpose

Since the disease is spread by means of transference of infected hairs, it was agreed that exclusion of children from school was of little value if they could mingle outside of school Moreover, the schools were the most convenient places for establishing treatment centers, because the children were there five days a week and lost but little time from classes while being treated Infected children of preschool age also could be brought more conveniently by the mother to the local school for treatment. Therefore, it was decided to permit infected children to go to school and be treated there

The barbers agreed not to cut the hair of infected children, but to send them to the treatment centers where the hair was closely clipped every ten days and where medicaments were applied by trained personnel every school day

The doctors agreed to send all infected cases to the treatment centers. The parents were instructed to shampoo the heads of infected children in the morning before coming to school, to supply the infected children with individual combs, brushes, and towels and with clean, closefitting caps which were to be boiled daily. They were also instructed that the heads of non-

<sup>\*</sup>Presented by invitation at the 141st Annual Meeting of the Medical Society of the State of New York Buffalo, May 7 1947, Section on Public Health, Hygiene and Sanitation

infected children were to be shampooed im mediately after receiving a hair cut in the barber shops. These measures served to control the spread of the disease so that upon subsequent re-examination of the schools six months after the first examination only 26 new cases were found, and one year after only 12 new cases were found. Half of these cases had not been examined before, because they had been of preschool age or had moved in from other localities.

It is agreed that the most efficient method of treating cases of tinea capitis is to epilate the scalp, following this with the application of fungicides. Epilation serves to empty the follicles of infected hairs, thus more easily per mitting the entrance of fungicides to kill the fungi remaining in the follicles. Epilation without subsequent treatment by topical application of fungicides usually results in the infection of the new hairs. A rays in epilation doses do not kill the fungi. Epilation may be done manually by pulling out the infected hairs, by exposure to x rays as originated by Sabouraud, and by the oral administration of one dose of thallium acetate, 7 mg. per kilo of body weight.

Manual epilation was used exclusively by dermatologists previous to 1910 and is attended with no danger but is tedious \tag any epilation requires special skill in order to give just sufficient dosage to obtain epilation and yet not to so severely injure the papillace as to prevent regrowth of the hair Epilation by the oral administration of thallium acetate is deemed dangerous by American dermatologists although it is being used in some other countries with no reported serious untoward results

Epilation by either x ray or thallium acetate permits the falling infected hairs to disseminate the infection, whereas when manual epilation is done the hairs can be burned

Dermatologists or radiologists expert in the use of x rays for epilation were not available in Hagerstown, as is the case in many other similar communities therefore we decided to dosely clip the hair of infected children every ten days at the treatment centers, burn the hairs and rely on topical applications for the treatment of the disease. Manual epilation of infected hairs was to be done on suitable areas of the scalp where only a few hairs were infected. In order to aid in the prevention of the spread of the infection all the infected children were required to wear caps at all times.

It was decided to evaluate the curative powers of the many well known remedies used for the treatment of tines capitis. Some cures were obtained by the systematic application of all the remedies tried, but some remedies proved more effective than others by ouring a larger percentage of the cases to which they were applied in a shorter time. However, many cases failed to respond to these remedies or improved up to a certain degree and then remained stationary and in a few cases began to spread again

During the war, at the request of the U.S. Quartermaster we tested for possible skin ir retant properties many chemicals commercially used as antimildows in order to determine their fitness for use on fabrics to be used in the tropics by our armed forces. Most of these chemicals were powerful fungicides but most of them were primary skin irritants and sansatzers.

We selected for trial on the stubborn cases of tinea capitis a few of the antimildens which we thought might be of value in curing these cases and yet would not be too irritating for use in the necessary fungicidal concentrations chlorophenols phonyl phonols phonyl mercurio salts, cationic detergents and salicylanilide were the antimildews we tried Because one of the popular proprietary remedies for tines. pedia, containing sine undecylenate had been used by us with rather indifferent success in the treatment of times capitle, we though that per haps if we substituted copper for zinc, copper undecylenate might give better results because copper steelf is a well known fungicide copper undecylenate was not on the market we made it in our laboratory

All of the chemicals were tried on at least 25 cases and the results showed that 5 per cent salteylanilide in Carbowax 1500 to which was added a cationic detergent Hyamine 1622, and a saturated solution of copper undecylenate in Carbowax 1500 gave the best results. These two remedies were the only ones used toward the end of our experiment and all the remaining cases were cured with them.

Pentachlorphenol 1 per cent in Carbowax, was third in the list of efficacy It will be noted that Carbowax was the cintment base we used in these three preparations and we feel that the physical properties of Carbowax as a surface activating agent played no small role in the curative properties of our remedies. Such a base enables the fungicide to enter the hair follicles and attack the fung more easily than if ordinary ountment base were used.

While these two fungicides gave the best results of the 17 that we tried they are not muracle drugs. In order to obtain good results they must be massaged regularly into the closely clipped scalp at least once a day for at least forty treatment days before the fluorescent hairs begin to disappear. If cures result sooner and sometimes they do so much the better, but some cases may require 100 or more treatments to get well and sometimes in cases where improvement

ceases it is necessary to alternate the two fungicides

If the parents wished to apply the medicaments at home, in addition to the applications in the treatment centers, we had no objections and sometimes cures were thus attained more rapidly. But we learned early not to depend on treatments at home

In addition to the application of the fungicides we also did manual epilation of the affected hairs when they occurred in small isolated patches

A newspaper campaign to educate the public on the hygienic measures to be used by them to help control the epidemic and to inform them of the progress being made was continued throughout the epidemic Circulars to the same effect were printed and given to the pupils to take home to their parents

These measures were so successful that in November, 1946, when we made our last visit to Hagerstown all the cases that were treated by us were cured. There remained only 13 cases of tinea capitas in the city, all having consistently refused to be treated at the centers.

# USPHS Method for the Control of Epidemic of Tinea Capitis

- 1 Meeting with city council, mayor, board of trade, and local newspaper representatives to provide money and publicity for the control of the epidemic
- 2 Meeting with superintendent of schools to obtain cooperation by establishing treatment centers in the schools and permitting infected children to wear caps in the classrooms
- 3 Meeting with the Parent-Teacher Association to obtain their cooperation (a) to permit the clipping of the hair of infected children in schools every ten days, (b) to provide caps for infected children and to sterlize them daily, (c) to shampoo the heads of infected children every morning before coming to school, (d) to provide individual combs, brushes, towels, and beds for infected children, (e) to instruct their children not to change caps, not to rest heads on the backs of movie seats, (f) to shampoo the heads of non-infected children immediately upon return from barber shop, (g) for teachers to see that infected children wear caps in the classrooms
- 4 Meeting with the local medical society to cooperate by sending all infected children to the treatment centers
- 5 Meeting with the Barbers Association to cooperate by refusing to cut the hair of infected children and sending them to the treatment centers, to sterilize all implements after using them to cut the hair of noninfected children

- 6 Meeting with the owners of the motion picture theaters to obtain their cooperation, by examining the plush and mohair backs of seats for fluorescent hairs with the Wood's light after the last performance every night and burning any that are found
- 7 Examination of the heads of all grade school children below the high school with the Wood's light and listing all the infected children
- 8 Establishing treatment centers in the schools
- 9 Supervision of the treatment placed in the hands of a dermatologist and equipping a laboratory with the necessary facilities for culturing and examination of functions.
- 10 The dermatologist shall train nurses or others to clip the hair of infected children every ten days, to burn the clipped-off hair, to do manual epilation, to apply properly the medication under a Wood's light, to keep adequate records
- If competent radiologists or dermatologists are available, \-ray epilation can be done on all who are willing and able to pay for the service
- 12 Epilated cases to be treated daily at the treatment centers until cured
- 13 All children under treatment to wear caps all the time in school, at play, at movies, etc
- 14 Caps to be sterilized daily at home, and the infected children given a shampoo every morning before coming to school
- 15 Criteria for cure When there are no more fluorescent hairs, cultures of hair roots should be made on Sabouraud's medium from areas that were infected. If no growth results the case is considered tentatively cured and treatment is discontinued. The patient is to return after one month and be examined with Wood's light. If there are no fluorescent hairs, the case is cured.
- 16 The preschool age contacts of all cases should be brought to the treatment centers and examined with the Wood's light Infected preschool children should be treated in the same manner as school children
- 17 Periodic inspections should be made of the barber shops to see that tools are properly sterilized
- 18 Periodic inspections should be made of "movie" theatres to see that the backs of seats are vacuum cleaned every night
- 19 Reexaminations of all school children should be made with the Wood's light every three months to discover new cases \*

The topical applications found by the Public Health Service to give the best results in Hagerstown study were

- 1 Salicylamlide 5 Hyamine 1622 (25 per cent) 5
- Carbowax (1500) 100
  2 Saturated solution of copper undecylenate
  m Carbowax 1500
- 3 Pentachlorphenol 1 Carboway (1500) 100

These fungicides have also been used with success in suitable solvents, such as alcohol ether and some of the volatile hydrocarbon solvents in which they are soluble, such as trichlorethylene.

\* These method have been used successfully to control the epid mics of ringworm of th scalp in Eikhart Indiana Takoma P rk, Maryland and Alamanee County North Carolina

#### DR BAYNEJONTS APPOINTED

Dr Stanhope Bayne-Jones appointment to the newly created position of president of the Joint Administrative Board at the New York Hospital-Cornell Medical Center effective July 1 was announced recently by Dr Edmund Eara Day president of Cornell and William Harding Jackson president of the New York Hospital. These institutions share in maintaining and operating the medical center at 68th Street and the East River

In making the announcement, Dr Day and 'In his new position, Dr Bayne-Joues becomes the chief executive of the Joint Board, made up of representatives of Now York Hospital and of Cornell University As such he will be responsible for the

formulation of policies and an over-all program for the Center President Day said that the position has been created in order to implement the Center's full potentialities for public sorvice. Both Dr. Day and Mr Jackson expressed confidence that in Dr. Bayno-Jones they had obtained 'the outstanding man for one of the most important positions in the medical world

Dr Bayne-Jones was formerly dean of Vale University School of Medicine and is currently serving as director of the Board of Scientific Advisers of the Jane Coffin Childs Memorial Fund for Medical Research and as professor of bacterology at Vale

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#### NATION WIDE SCIENTIFIC ATTACK LAUNCHED ON PROBLEM DRINKING

Announcement has been made of the first largescale action-wide attack on problem drinking by the Research Council on Problems of Alcohol, an associated society of the American Association for the Advancement of Science.

Organized ten years ago the Research Council has been working quietly and energetically in sponsoring individual research projects among leading scientific institutions to get at the fundamental causes of problem drinking, which affects the lives of over 750,000 people in the United States. The primary objective of the Council is to learn more about those

fundamental causes and to develop effective methods

of treatment and prevention.

The Research Council hopes to establish a series of research diagnostic treatment centers in leading medical schools and their affiliated hospitals throughout the country. One of the first of these has already been established at the Cornell University Medical College—The New York Hospital, under a grant of \$150,000 covering a five-year period. A chain of such centers, the Research Council feels, will provide many of the answers and much of the services needed to cope with this much neglected medical problem.

#### MEDICAL LICENSES REVOKED AND SUSPENDED

The Board of Medical Examiners of the State Education Department has announced the following revocations and suspensions to practice medicine in the State of New York.

Ibrahim J Abdallah, 7820 Ridge Boulevard, Brooklyn. License revoked, effective May 29 1947
 Simon Bloom, 113 East Second Street, New York

City License revoked effective May 28, 1947

D Garciano Perez, 156-08 Riverside Drive, New York City License revoked effective May 2, 1947

Hugo I Franceso, 635 East 211th Street, New York City License revoked, effective May 7 1947

Nicholas E. Caputo 120 Franklin Avenue Brooklyn License revoked, effective May 7 1947

Nicholas A. Tonia, 355 West 51at Street, New York City License revoked effective May 7 1947

Hirsch L. Messman 57 West 57th Street, New York City License suspended for a period of one year beginning May 20 1047

# NUTRITION AND CHILD HEALTH

RALPH R Scober, MD, Syracuse, New York

HE status of childhood indicates not only L emergence from infancy but also a milestone in the direction of the manhood and womanhood of the future citizens of the state toward maturity is basically dependent on the preceding nutrients supplied during each The newborn infant, stage in development for example, is the product of food elements furnished to the fertilized ovum by the mother It is obvious, therefore, that the structure of the infant may be optimal if these nutrients are supplied quantitatively and qualitatively in adequate amounts during fetal life Conversely, one would expect that quantitative and qualitative deficiencies of nutrients supplied to the fetus might result in structural and physiologic deviations from normal

In appraising the present health of a child, therefore, it is often desirable to obtain a history of what has transpired in its life, not only from birth, but also during fetal life. The preconceptional health and nutrition of the mother and her health and nutrition during the prenatal state often give valuable information regarding the health of the child during the formative or fetal stage of development One can, thus, often appraise the present status of an infant or child by carefully analyzing his or her nutrition status during each stage of development It is well known that certain nutrition deficiencies have effects on the individual lasting throughout It is possible, therefore, that many abnormal conditions that are observed throughout childhood had their beginning during fetal life and were primarily the result of poor nutrition of the mother

It has been shown by a number of investigators that a poor diet during pregnancy is not only detrimental to the mother, but also has harmful effects on the infant. Ebbs and associates found that during the first two weeks of life the condition and progress of the offspring of mothers who were poorly nourished was poor or bad in 14 per cent of their cases, as compared to none who came from mothers who were well nourished. It was noted that during the first six months of life there was a definite increase in the incidence of bronchitis, pneumonia, anemia, and feeding difficulties among the babies of poorly nourished mothers as compared with those of well-fed

Presented at the Public Hearing of the New York State Joint Legislative Committee on Nutrition, New York City December 11, 1946 mothers Tetany and rickets were not noted in the offspring of well-nourished mothers but were present in those of the poorly nourished mothers

Burke and associates found that 67 per cent of the infants born to mothers whose general dietary ratings were "poor to very poor" were stillborn, died within three days of birth, had congenital defects, were premature or "func-tionally immature" Twenty-eight per cent were considered in "fair" or "poor" condition, and only five per cent were in "good" or "excellent" condition Actually, all but one infant, in the senes of 216 cases, born to mothers with "good" or "excellent" diets during pregnancy, were in "good" condition at birth, while only two infants born to mothers with "poor" to "very poor" diets during pregnancy were in "good" condition at Although the "fair" to "very poor" diets in the foregoing studies were found to be deficient in several essential nutrients, they were generally found to be consistently low in protein

It must be admitted that an adequate, well-balanced diet is desirable for growth, development, and adequate functioning of the body. We cannot overlook the fact that the basic foundation of the diet, as of the body, must consist of protein. As its Greek root implies, protein is of first importance.

Protein not only is the most important constituent of the protoplasm of the body, but it is necessary for the formation of all living cells. It is required for the synthesis of body protein, plasma protein, hemoglobin, hormones, and enzymes, as well as the formation of secretions, such as milk. Adequate protein intake is necessary to form enzyme systems from vitamins. Protein is concerned with immunity, antibody formation, osmotic pressure, colloidal action, and specific dynamic action. It is capable of supplying energy to the body and participating in the detoxication of evogenous and endogenous toxins.

Protein, especially animal protein, is the most expensive food substance and during inflations and depressions protein of animal origin is unobtainable in significant amounts by all people because of diminished purchasing power. In time of war, it is not only expensive but scarce. Under such conditions protein deficiency states are probably more prevalent than is generally realized.

When protein is deficient in the diet, one would expect to find disturbances of many physiologic

processes in the body and the possible development of pathologic states It appears, moreover, that there may be not only a protein deficiency per se but secondary effects resulting from the inability of the body to utilize properly vitamins and minerals, and also interference with the normal function of the endocrine glands. The thyroid gland, in particular, is affected apparently adversely by a deficiency of protein, since a state of hypometabolism is often present. Diminution in size and secretory activity of the thyroid gland was particularly emphasized by those who studied nutritional edema in Europe in 1918 3 Some of the symptoms and signs of protein deficiency are strikingly similar to those observed in hypothyroidism, viz. low basal metabolic rate, hypotension, hypothermia, etc.

Inter relationships between the thyroid gland and other glands of internal secretion, and vitamin metabolism have been shown to exist appears, also, to be a parallelism of the symptoms noted in dietary deficiency states with the symptoms produced by an imbalance of the sympathetic nervous system It does not appear to be a coincidence that many of the symptoms of protein and vitamin deficiency, thyroid dysfunction, and sympathetic nervous system im balance are similar but rather it seems that an inter-relationship does exist. This inter-relationship with protein apparently playing a basically significant role, appears to be a factor in producing a symptom complex which has been observed in private practice and among school children.

#### Clinical Observations

Although the writer has advocated breast feeding for many years, he has found it in creasingly difficult for mothers to nurse their babies at the breast despite the fact that they are willing and anxious to do so. Inquiry has usually revealed that many of these mothers have subsisted on an inadequate protein intake during and after their pregnancies. Although they are supplied with additional quantities of vitamins calcum and iron during pregnancy, some of these mothers show signs of vitamin deficiency and anemia.

The offspring of many of these deficient mothers are small at birth at times premature. They often thrive poorly during infancy. Some of the infants gain rapidly in weight and become excessively large for their age. Umbilical hernia and undeveloped genitalia are commonly observed. Retarded dentition and signs of rickets are often noted. Respiratory infections are common. Many babies sleep poorly, are colicky or irritable.

Among those beyond the age of infancy a

symptom complex has frequently been observed in cases that give a history of a deficient protein intake. These children fail to respond significantly to supplementary vitamins although signs of vitamin deficiency are often present. However when the protein deficiency is corrected the response to vitamin preparations is more evident.

Although some of the children are underweight there are many who are of normal weight or over weight, according to accepted standards, but who manifest similar signs of deficiency Frequent and prolonged infections involving the akin, mouth, or respiratory tract have been noted in many of the children who have been mentioned

A mother will occasionally point out that her child falls easily, or that he appears to be clumsy One such case led the writer to suspect a brain tumor, but the child's symptoms responded to dictary supplementation. There is, at times, a history of injuries from relatively minor causes and often there is delayed healing in these cases.

The nervous system of many of the children patients apparently has been affected definitely by a diet that is found to be deficient in protein Many of the children are irritable and restless Biting the finger nails is frequently observed Some of these patients "go to pieces if the mother or teacher corrects them Many times the complaint is that the child will not sit still There are children who will not readily go to sleep, and others who wake up frightened, some are restless in their sleep.

There are complaints of fainting or dixmess. Some of the children tire easily or lack ambition others are retarded in their school work. Some complain of frequent headaches. Abdominal pain and constipation are often noted, and at times there are digestive disturbances. A number of children have vague pains in the extremities which often give the confusing picture of rheumatic fever. In some cases there is precordial pain

It has been observed quite often that receiving diets which are found to be deficient in protein have frequency of urination. Some have nocturia or enuresis. Vaginitis is commonly observed in girls.

The physical examination of many of these children often reveals the presence of puffiness of the eyes.\* In some cases there are dark circles beneath the eyes. The skin often shows a definite pallor less frequently, there is a pale, lemon color present. The postures are often

The puffiness of the eyes refers to a nonpitting awelling of the syslids and cyabrows, as well as the skin lateral to the re including that over the malar bone

poor and the muscles are flabby Some of the children have rough skins and coarse hair, others have lesions on the feet resembling burns or endermophytosis

The teeth of many of the children are found to be carrous, and it is noted in some cases that recent dental work has been done. A yellowish discoloration is frequently noted on the teeth of many children, including those who apparently have sound teeth.

The tonsils in many cases are found to be hypertrophied or diseased, however, in some instances it is noted that the tonsils are out, which would indicate that they probably had been hypertrophied or diseased

Tachycardia or bradycardia is not infrequently present, and a low blood pressure is often observed. In some cases the temperature is subnormal

Many of the children show evidence of having bitten their finger nails. Many of them have leukonychia (white spots) on the finger nails, this condition is frequently noted in states of thyroid dysfunction <sup>4 6</sup>

### Malnutrition in School Children

During the school year 1945 to 1946 it was noted, during routine examinations, that many of the children frequently showed signs similar to those that had been observed in private In order to correlate the puffiness of practice the eyes and the leukonychia on the finger nails with the physical defects that were observed. these findings were recorded on each chart the end of the school year, it was noted that of the 1.789 children who had been examined in four schools, 1,357, or 758 per cent, showed physical defects Three of these schools included many children in the lower economic group, the fourth school included children of a higher economic status The total number of children with physical defects who showed puffiness of the eyes was 514, and the number who showed puffiness of the eves and leukonychia Those children who had physical was 481 defects with leukonychia alone amounted to 144. and those showing neither puffiness of the eyes nor leukonychia amounted to 218 Thus, the children with puffiness of the eyes and those showing puffiness of the eyes and leukonychia ran almost parallel (Table 1) Although many of the children without physical defects showed puffiness of the eyes alone or with leukonychia, or leukonychia alone, yet the percentage was only 55 per cent as compared with 82 per cent in those children with similar signs who had physical defects Studies are being conducted now to determine during the school year how many of those with puffiness of the eyes, with or without

TABLE 1 —SUMMARY OF PHYSICAL EXAMINATIONS OF THE CHILDREN IN FOUR SCHOOLS SHOWING THE INCIDENCE OF PUFFINESS OF THE EYFS AND LEUKONYCHIA

Total Examined	1789
Total with Defects	1357
Puffiness of the eyes	514
Leukonychia	144
Both	481
Without either	218
Total without Defects	432
Puffiness of the eyes	70
Leukonychin	50
Both	121
Without either	191

leukonychia, and leukonychia alone, who had no physical defects last year will show evidence of defects this year

When the figures that have been mentioned above are examined in detail and compared with the individual defects, it is found that the number of children with defective hearing, vision, tonsils, teeth, heart, nutrition, posture, and skin are approximately the same in the group with puffiness of the eyes alone as in the group with puffiness of the eyes and leukonychia. Thus, there is a parallelism in the numbers showing similar physical defects in the group with puffiness of the eyes and the group with puffiness of the eyes and leukonychia (Table 2)

TABLE 2—Comparison of Physical Defects with Associated Puppiness of the Eyes and Leunonichia

Defective hearing Defective vision Tonsils Heart Nutrition	Leuko- nychia and Puffiness 13 30 100 25	Leuko nychia 3 10 22 3	Puffiness 9 26 102 16	Neither 4 18 42 7
Overweight Underweight Posture Skin	16	13	13	8
	108	39	91	46
	211	62	213	90
	36	10	33	5

# Nutrition Studies in Ringworm Infection

At the beginning of the school year 1945 to 1946, it was noted that children with ringworm infection of the scalp frequently showed puffiness of the eyes and often leukonychia, together with a high incidence of physical defects. Since many of these children appeared to be undernounshed and the widespread epidemic of ringworm infection throughout the United States seemed to run parallel with the rationing and shortages of food, it was decided to conduct an investigation with these facts in mind Although ringworm infection has affected a relatively small proportion of the school children in Syracuse, it has been a difficult disease to eradicate It often requires up to two years or more to combat it in the individual child with the methods of local therapy usually employed

With the corroboration of Dr Anne Bourquin, professor of nutrition, Syracuse University, and

her assistant, Emilia D Mainello, nutrition studies were made on four children with rangworm infection of the scalp A four-day dietary study was made on each chuld This investigation of the diet revealed that each of these children had dietary deficiencies of soveral food elements including protein as compared with the recommendations of the National Research Council All local therapy was discontinued in each of these cases and protein hydrolysate was given nt school and in supplements at home

The diagnosis of the ringworm infection was made and the progress of the disease was followed by the Wood filtered ultraviolet lamp Within ten days, two of these children showed marked in provement in the ringworm infection. One child showed unsatisfactory results and local therapy was resumed, the fourth child was afflicted with rheumatic fever after the start of the study and was absent for the remainder of the school

We were encouraged with these results and, therefore, began more intensive studies on a larger number of children with ringworm in fection Sexteen children were selected for these studies and they were divided into four groups. The ringworm of the scalp which was identified as the Microsporon audoumi infection, had persisted for over a year in spite of local therapy in all but two of these children A week's dietary study of the sixteen children revealed deficiencies of reveral nutrients in the diets, including protein as compared with the recommendations of the National Research Council The calone value of the diets was as great as 30 to 40 per cent deficient in several instances Nitrogen balance studies, conducted on four of the children prior to supplementing the diets, showed all of these to be in negative nitrogen balance

All of the children studied had puffiness of the eyes and poor postures. All but four had a yellowish discoloration of the teeth, and all but finger nail biters. Leukonychia was present on the finger nails of eleven of the children skin of four children had a pale-lamon yellow color five had coarse hair seven had dark circles beneath the eyes four were ten per cent or more underweight two had hypertrophied tonsils, and two had heart murmurs

One group of these children was given protein hydrolysate and a liver-stomach concentrate sodium iodide, 10 mg per week, was given to a second group in addition to the customary diet. The iodine was employed to determine whether or not the beneficial effects of local iodine therapy might be dependent to some degree upon absorption and systemic action Protein hydrolysate was prescribed for the third group fourth group was given a balanced diet fortified

with supplementary vitamins to correct the dietary deficiencies indicated by the dietary studies

The most rapid and greatest amount of im provement in the ringworm infection was noted in the groups receiving protein hydrolysate One child in the group receiving rodine internally made outstanding improvement. The results in the group receiving a diet balanced with natural proteins and supplementary vitamins were not as rapid nor as obvious as those receiving protein hydrolysate We attributed this result to the fact that the protein deficiency had probably produced a disturbance in digestion and assimila tion and that protein in a form such as protein hydrolysate, which requires little or no digestive preparation resulted in a more evident response than natural protein The observation that the administration of internal loding was effective in the treatment of one of our cases might imply that there was an iodine deficiency present

Experiments conducted this school year on a small series of cases also appear to indicate that an rodine deficiency may be present in some cases of ringworm infection The application of rodine to the area of the scalp affected by ringworm was discontinued in five cases and applications were made on other parts of the body. The results in these children were comparable to those observed when rodine was applied directly to the area of the scalp involved by the ringworm.

Our studies, though limited in extent, would appear to indicate that the nutrition status of a child influences the susceptibility and rate of healing in ringworm infection. It might therefore, be assumed that the nutrition status of the child is playing an important role in the increased incidence of the ringworm infection which has been noted throughout the United States since the onset of World War II

#### Conclusions

The need for scientific nutritional studies as well as a nutrition program to compensate for the undequacies in the home dietary and thereby. provide a completely adequate diet for the school child, is clearly indicated. When we reshire the need for wider acceptance of these requisites we will have healthier children as well as children who are mentally equipped to face the future with greater security

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# DIETHYLSTILBESTROL AS AN AID IN THE TREATMENT OF PSORIASIS

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THEORIES as to the cause of psonasis are numerous and, as in any disease of unknown etiology, the treatment is varied and not very satisfactory. Out of the maze of clinical and laboratory findings there is much to indicate a relationship between the endocrine system and psonasis.

The value of sunlight in psoriasis has long been known, and the fact that the disease is rare in the Negro suggests a relationship between melanin on one hand, and the adrenals or gonads on the other

Reynolds1 states that "if hypogonadal individuals (man or woman) are exposed to sunlight they fail to tan readily although an invisible change takes place in the tissues androgens or estrogens are miected subsequent to exposure to ultraviolet light, pigmentation of the skin occurs without further exposure to light Injections of the hormones into nonphotosensitized individuals fail to elicit pigmentation The relation of this phenomenon to the mechanism of carotin and melanin is unknown suggestive that sex hormones have a sterol nucleus somewhat similar to that of adrenal cortical hormone in the absence of which coloration of the skin characteristic of Addison's disease takes place"

Fat metabolism has long been believed to play a role in psoriasis, although the findings of a hypercholesteremia have been contradictory:

Gruneberg<sup>3</sup> and others believe the adrenal plays an important role in psoriasis. LeWinn and Urbach<sup>4</sup> in a recent article sum up the evidence in the following manner Definite decreases in urinary vitamin C excretion, the decrease in the amount of sulfur excreted in the urine, and the increase in the blood potassium level all found in psoriasis, infer a relationship between this disease and the adrenal cortex

Unfortunately, the therapeutic application of this relationship has produced no uniformly successful result, and treatment is still mainly directed at the local condition of the skin rather than by the use of any systemic therapy

Madden<sup>5</sup> treated 6 patients with 1 cc of adrenal cortex hormone twice a week. His results showed no improvement in 5 cases and improvement in one case. LeWinn and Urbach<sup>4</sup> treated 18 patients with ascorbic acid, adrenal cortex extract, and a low potassium diet, and could not observe any definite benefit from this type of therapy

The use of female sex hormones has been tried with both encouraging and discouraging results.

The problem remains that there is still much to indicate a hormonal relationship, but what this relationship is, or which glands are involved, is still a matter of conjecture. The thyroid, the pituitary, and the pancreas have all been considered at some time, but no new light his been shed on the subject.

It is obvious from a perusal of the literature that the exact mechanism of the endocrines is far from a solved problem. Nor is it clear of the many component substances these glands secret. Could a deficiency of some of the unisolated hormones or a defect in their synergistic action be at fault?

With this in mind, an attempt was made in a series of cases to stimulate the adrenal gland indirectly through the action of diethylstil bestrol on the pituitary gland It has been shown that the administration of diethylstil bestrol results in an increase in the weights of the pituitary and adrenal glands in both male and female animals 10 Von Haem 10 also noted that the increase in both these glands was much greater in animals treated with stilbestrol than those treated with equal doses of estrone, and that the adrenals became brownish-red in color and the pituitary appeared more hyperemic. The Smiths 11 state that stilbestrol appears to be about one hundred times as active as estrone in eliciting the pituitary responses of intact animals, although only about twice as active in castrated The pituitary effect obtainable in the animals presence of testes indicated that its metabolism was not regulated by the same mechanisms as The authors the naturally occurring estrogens noted that probably stilbestrol's effect on the pituitary gland is direct rather than through the formation of some metabolic inactivation product as appears to be the case with estrone.

In addition to a stimulating effect of diethyl-stilbestrol on the adrenal gland, it has been shown that sex hormones and suprarenal cortical extracts have a close structural relationship, and have a similar effect on the excretion of electrolytes 13. The administration of both results in a decrease in the renal excretion of sodium and chloride and an increase in potassium excretion.

# Material for Present Study

Twenty patients with unquestionable psoriasis

were treated with diethylatilbestrol The treatments were carned out from March through Due to the small number of cases avail able and the difficulty of holding the patients for a sufficient trial period, adjuvant local therapy was used at first. It was found later that the most successful therapy was a combination of the two There were eight men and twelve women included in the senes, and their age groups ranged from nineteen to forty-seven years of age The daily dosage of diethyl stilbestrol was 2 mg, except in those women who still menstruated on this dose women were given 4 to 5 mg daily as it was felt that inhibition of monstruction was a good guide to adequate therapy

#### Clinical Study

Five patients whose enset of psoriasis was of very recent date (from one week to two months) were treated with diethylstillectrol by mouth and 1 2-3 contment\* to the right half of the body only. After one month improvement was noted on both sides of the body, but the improvement in the area where the cintment had been used was so marked that it was then decided to use the cintment on both areas. The scalp, when involved was treated with equal parts of lanclin petrolatum, and oil or not at all. Complete clearance of all lesions was obtained in all 5 cases. The time interval required ranged from five to ten weeks.

Two patients were treated with diethylstil bestrol by mouth and none locally Both were chronic psoriatics and had had much local therapy and ultraviolet light previously with indifferent results. One of these patients showed a moderate improvement after five weeks on this therapy. The other remained stationary Ultraviolet in weekly suberythema doses was then added to the therapy and both showed marked improvement. The lessons completely disappeared in one patient after a total of eight weeks' treatment.

Three cases of chronic psoriasus were treated with diethylstilbestrol by mouth generalized ultraviolet radiations and 1 2-3 ointment applied locally Improvement was noted in two cases No change was noted in the third case.

Seven patients, all chronic cases of psonasis were treated with diethylstillsestrol by mouth and 12-3 outment locally to half of the body. When slow improvement was noted a stronger ointment of ammonated mercury and sallcylic acid, both 3 per cent in a sine oude ointment base, was used on the half of the body previously untreated. Improvement was more rapid in

five of these cases. Two cases showed little change.

Two cases both of whom had had their lesions for many years and had received much previous local treatment and ultraviolet light, were treated with diethylstilbestrol by mouth and an ointment of oil of cade and chrysarobin locally, combined with ultraviolet light. Both cases improved rapidly and in six weeks were completely free of all lesions.

Treatment of one patient was discontinued in the third week due to severe edema of the ankles which occurred while on diethylstillestrol ther apy. This was the only reaction severe enough to necessitate stopping the drug. Another patient stopped the drug for four days due to severe nausea, then felt that her improvement had been so great that she would try to tolerate the nausea. No nausea was experienced on retaking the drug. Four other patients complained of nausea which either disappeared or remained mild enough to continue with medication. Painful breasts and a fullness of the breasts were complained of by four men and three men stated that they had lost their sex desire.

#### Summary

Of twenty cases of psomasis treated with diethylstilbestrol as an adjuvant to local therapy, eight cases were completely cleared of all lesions. Five of these eight cases were very early cases of psomasis, treated within two to eight weeks of the development of their original lesions.

Ten cases showed from moderate to marked improvement over a period of six to ten weeks Most of these ten cases had been receiving the same type of local therapy for long periods of time prior to the addition of diethylstilbestrol to their therapy

Three cases of psoriass showed no improvement Treatment was discontinued in one patient due to toxic reaction from therapy

Of the eight cases cleared of leaons one case has relapsed within two months. Whether therapy was stopped too early to prevent regression, or if improvement is present only when diethylstilbestrol is being taken is undetermined thus far. Further work will have to be done to determine this

Of the eight cases completely cleared of all lesions, five were women and three were men of the improved cases, five were women and three were men of the failures one was a woman and two wore men one woman stopped thempy after the third week due to a tone reaction.

In the cases benefited the improvement in the first three weeks of therapy was slow or indifferent. After three weeks, improvement was more apparent and rapid

<sup>9</sup> Liquid aluminum acetate 10 parts; lanolin 20 parts; and sinc pasts 30 parts

### Conclusion

Diethylstalbestrol is a valuable adjuvant to the treatment of psonasis It is believed that its effect is through an indirect stimulation of the adrenal gland

Diethylstilbestrol alone is insufficient therapy. although it seems that sometimes the only other addition required is a bland ointment used locally and regularly upon the skin

Early cases of psomasis before the skin changes, becoming thickened and torpid, are most benefited by therapy

Chronic cases of psoriasis who were previously treated for long periods of time showed an improvement by the addition of diethylstilbestrol to the therapeutic regime

55 RUGBY ROAD

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## STATEMENT BY THE ACTING COMMISSIONER OF HEALTH ON LIVE ANIMAL EXPERIMENTATION

Rules governing the care and treatment of living animals used for scientific research by laboratories and institutions in New York State were promulgated by Dr James E Perkins, deputy and acting state commissioner of health, and were filed June 2 with the Secretary of State They will implement an act passed this year by the Legislature, effective July 1, 1947, which requires approval by the State Commissioner of Health before a laboratory or an institution can conduct experiments involving the use of living animals Approval of laboratories under the new law will be granted for a period not to exceed one year In announcing the new rules, Dr Perkins said

"Every decent person, I am sure, will welcome this additional safeguard against unnecessary experiencing of pain by such animals. At the same time, neither the law nor these rules will hamper in any way legitimate scientific studies leading to reduction in misery and suffering of both human beings and No person who understands the tremenanimals dous accomplishments of such research in the past would want it interrupted

"Thousands of persons now leading happy, useful lives have escaped agonizing, prolonged suffering and even premature death solely because of the knowledge and skill learned through research with animals in the past A few of the advances made through such research in combating the ills of mankind are the improved methods of treating diabetes and cancer, and the operations through which 'blue babies' with congenital malformations of the heart are restored to normal lives instead of being condemned to invalidism and early death

"Furthermore, thousands suffering today may at least have the comfort of assurance that their children may escape similar suffering, as the result of scientific studies with the use of living animals which are being carried on at present, or will be conducted in the future

"Animals which are contributing so much to human welfare are entitled, however, to clean, well lighted, adequate quarters maintained at a com-fortable temperature. The great majority of experiments can be conducted painlessly and any pain or discomfort obviously should be avoided whenever possible In the occasional instance in which a procedure must be employed in an important experiment which will result in pain, care should be taken to cause as little discomfort as possible, and the evperiment should be undertaken only with the express permission of the scientifically qualified, responsible individual in immediate charge of the work in the laboratory

The rules which have been promulgated in accordance with the provisions of this new act will further insure that such rights of animals used in scientific studies will be respected "-Health News, June 16, 1947

### ATOM BOARD NAMES 7 MEDICAL ADVISERS

The United States Atomic Energy Commission announced on June 15 appointment of a special medical board of review of seven scientists in medicine and biology who will advise the commission on atomic research in the medical and biological fields

The members of the board are Dr Robert F Loeb, chief of the division of medicine, Presbyterian Hospital, New York City, chairman, Dr Detlev W Bronk, chief radiologist, University Hospital, Phila-delphia, Dr Wallace O Fenn, professor of biology,

University of Rochester Medical School, Rochester, Oliversity of Rochester Medical School, Rochester, New York, Dr Herbert S Gasser, physiologist, Rockefeller Institute for Medical Research, New York City, Dr Ernest W Goodpasture, dean of the School of Medicine, Vanderbilt University, Nashville, Tennessee, Dr Alan Gregg, director for medical sciences, Rockefeller Foundation, New York City, and Dr A Baird Hastings, professor of biochemistry, Harvard Medical School, Cambridge, Massachusetts Massachusetts

#### MENINGOCOCCIC MYOCARDITIS

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THE recent literature has been replete with studies of myocarditis occurring during the course of various infectious diseases, such as diphthena, scarlet fever, pertussis, measles 'mumps,' scrub typhus,' influenza,' malarna,' infectious hepatitis,' atypical pneumonia,' and pneumoeoccus pneu monia.' In many of these instances the diagnosis of myocarditis was made only because the investigator was alert as to its possibility

A review of the literature concerning meningococcic myocarditis similarly indicates the need for alertness as to its possibility. Holman and Angevine' state that acute myocarditis is not an uncommon complication of acute systemic infection and cite 2 cases of meningococcic myocarditis. In their first case a fatality the heart did not attract their attention. As a result of this experience, clinical and electrocardiographic investigation of the second case led to the dilagnosis.

Otto Saphir10 reported 240 cases of my ocarditis in a series of 5 626 autopaies two of which were due to the meningococcus. Saphir<sup>11</sup> also found myocarditis due to the meningococcus in 2 cases in a series of 15 of meningocoecus meningitis. In 1939 Hartwell12 reviewed the literature and found 17 instances of meningococcio endocarditis and 12 of meningococcie myocarditis The cardiac lesion found most frequently was an involvement of the endocardium of the mitral valve. Rappaport and Luckerbrod18 reported a case of meningococcemia with meningitis myocarditis, and pulmonary involvement. MacMahon and Burkhardt14 reviewed 12 cases of meningococcic endocarditis, all of which were fatal and observed that most of these were not recognized chnically. The authors believe that endocarditis can be caused by the meningococcus without there being any evidence of meningeal in volvement. Rhoads, 18 similarly reported cases of vegetative endocarditis due to the meningococcus. without clinical evidence of meningitis. Gwyn16 reported a case of subacute meningococcic endo-

bacterial endocarditis.

The usual picture of meningococcic endocarditis is
that of a bacteremia plus valvular involvement.

It may run a subacute course, characterized by joint
pains and eruptions that are maculopapular or
hemorrhagic in character The spleen may be enlarged and there may be abuminuria and hema
turia in According to Swift, it four reactions in the
joints are common symptoms of meningococcic
sepsis.

carditis which followed the classic form of subacute

Scherf and Boyd<sup>10</sup> state that electrocardiographic studies show that every case of endocarditis is accompanied by some myocarditis. Meningococcic abscesses of the myocardium have been reported and quoted by Saphir <sup>11</sup>

Neubauer i in a study of myocarditis in acute infectious diseases found that myocarditis can be present with doubtful or absent chnical signs and symptoms. Pallor, listlessness or vomiting may be the first sign. Albummuria may be present. The first sound at the apex may diminish in intensity or be equal to the second sound. Later it may be in audible. Other symptoms include persistent tachy cardia gallop riptime, cardiac enlargement low blood pressure, and a low diastolic level. Electrocardiographic studies reveal flat. T waves which later become isoolectric and then inverted. The ST segment is below the isoelectric line in leads 1 or 2 or both. The sum of the voltage of T waves in the limb leads is less than 1.5 millivolts.

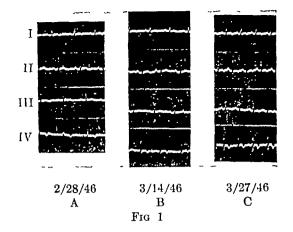
Many postinfectious convalencent cases whose condition is unsatisfactory may be suffering from myocarditis rather than from a vague asthemi low blood pressure or psychoneurous. This has been demonstrated by a recent review of acute non-specific myocarditists occurring during infectious processes.

The following case report seems interesting from several aspects. First, a fortuitous circumstance led to the diagnosis Second marked electrocardiographic changes were revealed that persisted over a long period of time. Third the postmeningitis convalescent care of the patient was modified properly as a result of early diagnosis. Fourth it affords an opportunity to stress the need for alertness as to the possibility of myocarditis in all infectious diseases.

#### Case Report

This patient, V. R., a woman aged 23 artist by occupation was admitted on January 27, 1946 and remained in the hospital until May 5, 1946 She was admitted in a semicoma with a history of the onset of her illness with occipital headache multiple joint peans stiff painful neck and sore throat. A petechial rash had appeared on the body a few hours before admission. The only significant point in her past history was that of a cervical spine injury at the age of 6 which had left her with persistent neck peans and recurrent headaches.

Physical examination on admission revealed con junctival petechlac generalized cutaneous petechlac and eech moest over the trunk. The heart was normal in size, no murmurs were suddiel. Rhythm was regular with a rate of 112 P. was greater than A<sub>1</sub> Movement of the knees, ankles and cllow joints elicited pain. Kernig and Brudsinski signs were positive. The neck was rigid Temperature was 102 6 F. Blood pressure was 107 80. Urinally sis was negative. Spinal fluid on admission was cloud, with 14,300 white blood cells per ce. The differential was 78 per cent polymorphonuclears and 22 per cent lymphocytes. Globulin was 2 plus, gluesse 10 chorides 641 and total protein 216. Smear showed gram-negative intracellular diplococcus, and culture showed neissoria meningitides. The diag



nosis was meningococcic meningitis and meningococcemia. The treatment consisted of 6 Gm of sulfadiazine daily with 12 Gm of sodium bicarbonate orally, following an initial intravenous dose of 4 Gm of sulfadiazine Penicillin was given in doses of

50,000 units every three hours

The temperature fell rapidly and after forty-eight hours reached normal The petechiae faded and the nuchal rigidity was slight Due to a change in services at that time sulfadiazine was inadvertently continued until February 7, with a resultant (?) rise in temperature to 102 F on January 31, which was maintained to 104 F on February 6 On February 6 spinal fluid was crystal clear Study showed 6 lymphocytes, with no polymorphonuclears organisms were found on smear or culture Glucose Kahn and was 70, globulin negative, chlorides 640 colloidal gold tests were negative Following the discontinuance of sulfadiazine, the temperature promptly fell to normal in twenty-four hours Penicillin was discontinued on February 10

The temperature remained flat until February 19, when there was a sudden rise to 103 F. This persisted for seventy-two hours, then fell to normal and remained so until March 24 when it reached 101 to 102 F for forty-eight hours and again subsided to

normal, where it remained until discharge

On February 11 pain in the right ankle with swelling and tenderness was noted. There was no redness nor limitation of motion. Pains in both ankles

continued until April 1

On February 6 the patient complained of lower sternal pain. Chest plate at the bedside revealed slight elevation of the left diaphragm. On February 19 coincident with the onset of the seventy-two-hour temperature rise which was noted above, the patient complained of pain in the left axilla and scapular area aggravated by breathing Examination showed diminished breath sounds in the left chest and an apparent splinting of the left chest. A diagnosis of acute pleuritis was made

With the continuance of the joint pains and the elevated sedimentation rate of 5 mm in five minutes on February 25, an electrocardiographic tracing was advised, although physical examination of the heart remained noncontributory The electrocardiographic tracing on February 28 (Fig 1A) revealed the following PR interval 0.20 seconds, QRS 0.08 seconds, rate 74 per minute, T<sub>1</sub>, T<sub>2</sub>, and T<sub>4</sub> were negative, and of the so-called "coronary contour" ST<sub>2</sub> was 0.5 mm above the isoelectric line Similar electrocardiographic findings were noted on March 14 (Fig 1B) On March 21, all T waves were negative.

tive This was also noted on March 27, (Fig. 1C), April 4, and April 9 On April 21 and on May 11 all

T waves were diphasic

The pains in the ankles continued, and on March 23 knee pains were present On March 26 pains in the neck, shoulder, and interscapular region were noted, with a temperature rise to 101 F The sedimentation rate, which had fallen from 5 mm in five minutes on February 25 to 2 mm in five minutes on March 15, was again 5 mm in five minutes peated blood cultures on February 7 and 18, and March 27 were negative. Blood chemistry and urine examination proved negative On March 29 clinical anemia was noted and corroborated by labo-The hemoglobin was 66 per cent and ratory study the red blood cell count was 34 million mission these values had been 86 per cent and 43 At this time, the possibility million, respectively of subacute bacterial endocarditis was considered

After April 1 the patient had no further complaints. The temperature and sedimentation rates remained normal. On April 19 she was allowed out of bed with graduated activity and was discharged on May 5. The final diagnosis was meningococcemia, meningococcie meningitis, toxic pleuritis, and toxic myocarditis secondary to the systemic

meningococcic infection

Subsequent study of the patient on December 18, 1946, seven months after discharge from the hospital, revealed her to be symptom free — She had returned to her normal activities and had no limitation of cardiac function — Physical examination was entirely negative and electrocardiographic studies including multiple precordial leads revealed entirely normal findings

### Discussion

The case reveals unmistakable evidence of meningococcic meningitis overtreated with sulfa and a resultant drug fever The prolonged arthritic manifestations are a well-known postmeningococcic sequel with or without meningococcemia electrocardiographic changes have been interpreted as due to myocarditis, although the ST elevation changes and T wave negativity may occur in acute The ST elevations were, however, pericarditis transient and not very striking at any time. It is interesting to note that an electrocardiographic pattern typical of pericarditis has been noted clinically 31 and experimentally22 secondary to sulfonamide administration with subepicardial necrosis as a postmortem finding in both instances

French and Weller<sup>23</sup> have reported interstitial myocarditis associated with sulfonamide therapy and have reproduced an eosinophilic type of diffuse myocardial reaction in animals given therapeutic doses of sulfonamides Wells and Sax<sup>24</sup> have reported a case of isolated myocarditis probably of

sulfonamide origin

Obviously, the differential diagnosis in our case includes meningococcic myocarditis, meningococcic pericarditis, sulfonamide myocarditis, and a concomitant acute rheumatic fever. The pericarditis has been excluded for the reasons given above, the persistence of the findings long after withdrawal of the sulfonamide tends to exclude it as a factor, acute rheumatic fever cannot be ruled out.

We believe that recognition of the cardiac involve-

ment and further observation of the process by clinical and laboratory measures may have obviated further complications.

#### Summary

- 1 We have reviewed briefly the partinent litera ture.
- 2 The problem of infectious myocarditis has been stressed
- A clinical case of postmeningococcie myocarditis has been presented
- A plea has been made for intensive study of all infectious cases for the possibility of cardiac involvement

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#### "DOCTOR JONES" SAYS-

Is general practice of medicine becoming a specialty? That question was the subject of one of the best articles I ve read in some time. It was by a specialist an Albany surgeon. His answer is that, of all the various fields of medicine, the most essen tial and the most difficult the one requiring the broadest knowledge and involving the hardest work. is that of general practice. And yet, as he infers, all the recognized specialists get paid more for their services than the general practitioner does. He thinks he, too, should be rated as a specialist and paid on the same scale as the others.

He says he sin t talking about the "intellectual and physical loafer the fellow that when he gets his medical degree, considers his education complete and settles down to being a mere pill-peddler There's that kind of course, in every profession And being able to graduate from a medical school and pass licensing examinations is no guaranty that they'll be good doctors He s talking about the ones that re not only well educated and trained but road their medical journals, attend meetings and post-graduate lectures and know their stuff and their limitations, in other words, the ones that re competent.

Eighty five per cent of human ills, this surgeon

eays could be adequately cared for by the competent general practitioner. He cites the treatment of gonorrhea as an example. The average case he says can be cured inside of three days with peni 'Why,' he says should one man receive a cillan larger fee than another both using the same drug and the same technic in uncomplicated cases? And if any of us, he says were where we could only have one doctor who wouldn't feel eafer with a competent general practitioner than with one from any

other medical group? Naturally I agree with him But the very fact that, as he says, the general practitioners are the public s first and last line of defense against disease raises another question. What about the thousands of low income but self respecting and, ordinarily self-supporting families that can't even afford the foes he charges now-inadequate as they are? How to take care of them in my opinion is the one impor tant feature of this so-called medical care problem. If they'll give these general practitioners a chance and a little encouragement, maybe they il work it out.—Paul B Brooks M.D. Health News June 9 1947

\* New York State Journal of Medicine April 15 1917 p 874

#### INTERSTATE CONFERENCE TO AID RABIES CONTROL

The latest development in New York State s program to control rables is the participation of its Department of Health in an exchange of ideas and information among several Northeastern states.

Results of an initial interstate conference here have been viewed by Dr Akxander Zeissig, rabies consultant in the Department, as another forward step in our effort to bring rables under control particularly in curbing the spread of the disease from one state to another

The meeting brought together representatives from Vermont, New Hampshire, Massachusetts, Rhode Island Connecticut Pennsylvania, New Jer

soy New York, and Georgia The United States Public Health Service was also represented

Dr Zeiseig outlined the control program in New York with specific reference to the disease in dogs Gardner Bump superintendent of game in the Concarvation Department, discussed the control program in the state as it is being applied to foxes Dr E. V Moore deputy commissioner of the Department of Agriculture and Markets spoke on con-trol of rables in cattle A general picture of the attuation throughout the nation was presented by Dr James H Steele U S Public Health Service Dr Robert F Korns, assistant director of the Divi sion of Communicable Diseases, presided.

# RITTER'S DISEASE IN FRATERNAL TWINS, WITH SPECIAL REFERENCE TO THE PATHOGENESIS

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(From the Serological Laboratories of the Office of the Chief Medical Examiner of New York City)

N 1878, under the title of dermatitis exfoliativa neonatorum, Ritter von Rittershain described a rare exfoliating skin disease of newborn infants This disease is so rare that only occasional reports can be found in modern medical literature, but a good account of the disease is given in most standard texts on dermatology, as in Ormsby and Montgomery 1 The etiology and pathogenesis of Ritter's disease has never been satisfactorily elucidated, Ritter himself believed that disease to be pyogenic Some workers have classified this disease as a malignant form of pemphigus of infants, others consider it a form of epidermolysis, while still others consider it merely an exaggeration of the normal ex-The purpose of this comfoliation of the newborn munication is to report the occurrence of this rare disorder in newborn fraternal twins, and to propose a theory to explain the pathogenesis of the condition

## Case Report

The patients were boy twins born on July 17, 1946, approximately seven weeks prematurely. While they closely resembled one another, blood tests performed later proved that they were fraternal rather than identical twins. The results of these blood tests on the parents and the twins are given below for purposes of reference.

Blood of	Group and Subgroup	M-N Type	Rh-Hr Type
Father	$\mathbf{A_1}$	N	Rhz
Mother	0	MN	rh -
Twin A	Ó	MN	rh
Turn B	Α,	N	Rh.

It will be noted that the mother is Rh negative and the father heterozygous Rh positive—In addition to the incompatibility with respect to the Rh factor, there is an incompatibility in the blood groups, the mother belonging to group O—and the father to group A—Since such incompatibilities can give rise to erythroblastosis fetalis, it may be stated at the onset that we had been aware of this situation during the pregnancy, because the mother was a research fellow who had been working in the field of the Rh blood types—Since this was the mother's first pregnancy and she had never received a blood transfusion or blood injection, there was no reason to anticipate the occurrence of erythroblastosis in the expected infants—In addition, tests on the maternal serum during pregnancy proved that she was not sensitized either to the agglutinogen Rh or to agglutinogen A \*

At birth, twin A weighed 4 pounds, 6½ ounces, while twin B weighed 4 pounds, 7 ounces. They were both kept in incubators and placed on a formula. By the time they were two weeks old they both weighed more than 5 pounds and seemed to be making satisfactory progress, so they were discharged from the hospital. About a week after their arrival home, reddening of the skin was noticed on both twins, particularly on the neck under the chin and in the groins. The lesions gradually spread and

covered the body so that soon the entire body was erythematous and covered with vesicles. The vesicles ruptured, then dried, and this was followed by exfoliation. While there was no recurrence of vesiculation, the process continued, so that after peeling occurred, the underlying skin remained edematous and reddened, and peeling recurred over and over again. The general condition of the infants began to go downhill, particularly in the case of twin A, whose cry became feeble and who fed poorly However, the course was entirely afebrile without any evidence at any time of the presence of infection.

One month after the onset of the disease twin A seemed critically ill and blood counts were done which showed the following Twin A had a hemo-globin concentration of only 55 per cent, a red blood count of 2,730,000 per cmm, white blood count of 11,000 per cmm with a differential count of neutrophils 29 (6 bands), small lymphocytes 33, large lymphocytes 30, monocytes 5, eosinophils 1, myelocytes 2 The blood smear showed anisocytosis and polychromasia, and there were 4 normo-blasts per 100 white blood cells The blood count on twin B showed a hemoglobin concentration of 72 per cent, a red blood count of 3,380,000 per cmm, white blood count of 12,000 per cmm, the differential count revealed 41 neutrophils (16 band forms), 38 small lymphocytes, 13 large lymphocytes, 4 monocytes, and 4 eosinophils The blood smear showed less pronounced red cell changes than in the case of twin A and there were only 2 normoblasts per 100 white blood cells Both twins evidently now had a secondary anemia, and the more severe anemia in the case of twin A corresponded with his critical clinical condition

Blood was drawn from the mother of the twins, and the red cells washed twice with saline solution. Fifty-five cc of the packed red cells diluted with a small amount of saline were then transfused to twin A, and 30 cc of the packed red cells to twin B Following the transfusions, the general condition of the twins improved markedly, especially in the case of twin A. While the exfoliation of skin continued for another month, the infants fed better, put on weight, and gradually improved in all respects. A report received, when the twins were four months old, stated that they were both entirely well, twin A weighing 10 pounds 9 ounces and twin B 10 pounds. Since this paper was completed, the twins have continued to develop normally, and to date (July, 1947) there has been no recurrence of the skin dis-

Two alternative explanations suggested themselves to account for the occurrence of Ritter's disease in the fraternal twins,\* namely, that the condition was due to either infection or some sort of sensitization. The possibility of infection seemed to be excluded by the afebrile course of the disease its simultaneous appearance in both twins five weeks after birth, and the clinical course and blood

<sup>\*</sup> For a review of the most recent developments in the field of the Rh-Hr types and crythroblastosis see Wiener 2.3

<sup>\*</sup> This diagnosis which seems the only logical one to make in view of the clinical course of the disease was first suggested by Dr David Bloom when he saw the infants in consultation

count findings. With regard to isosensitization to the Rh or A factors as possible etiologic factors this was excluded for reasons already given, and, besides both twins were affected despite the difference in their groups and types, the twin with the compatible blood type being the more severely affected.

The mother was questioned as to the occurrence of any dermatologic lesion or any other type of sensitization in herself particularly during preg nancy She then stated that during the sixth month of pregnancy she had had a severe attack of poison ivy dermatitis.\* The leaons which first appeared on both knees and on the neck, later spread over almost the entire surface of the body involving the abdomen breasts, and both arms up to the elbows. The lesions gradually cleared but vesicles were still present up to one week before the delivery of the twins.

In view of this history the following hypothesis suggested itself to explain the occurrence of exfoliative dermatitis in the twins. The toxic princi ple in posson ivy responsible for the dermatitis in the mother presumably combined with her skin proteins and altered them sufficiently so that they became antigenic and stimulated the production of skin antibodies. The skin antibodies in turn combined with skin proteins on other parts of the body giving rise to erythema and vesiculation of previously unaffected portions of the skin surface. This could account for the particularly severe and extensive nature of the dermatitis in the mother The skin antibodies would be capable of traversing the pla cental barrier into the fetal circulation, where they could combine with the skin proteins of the fetus. As is well known, the skin of newborn and particularly premature infants is refractory to antigon antibody stimuli This could account for the delayed onset of the disease in the infants until five weeks after birth Thus, the hypothesis would account for the occurrence of the disease in both twins simultaneously in the absence of any evidence of infection and despite their difference in blood groups. It would also account for their complete recovery which would be expected after the skin antibodies were exhausted, provided the infants did not die from the effects of the dermatitis. An attempt was made to demonstrate the presence of skin antibodies in the serum of the mother of the twins by injecting some of her serum intradermally into three volunteers including the writer and the nationt herself. The injections did not cause the appearance of any lesions but inasmuch as this test was done four months after the birth of the twins the antibodies may well have disappeared by this time. It is hoped that this report may help to call attention to the possibility of skin antibodies as an etiologic agent in other similar or related cases so that tests can be made at the height of the disease DECCESS

As experimental evidence supporting the thesis of skin antibodies the work of Hecht, Sulzberger and Well<sup>4</sup> may be cited. In experiments on rabbits these workers found that unaltered skin protein was not antigenic for animals of the homologous species However when the skin protein was altered by mixing it with staphylococcus toxin, the production of skin antibodies could be stimulated. That autoantibodies against other tissues besides skin can give rise to pathologic changes has also been suggested in the past. The role of the autohemolyans and autohemagglutining in the pathogenesis of hemolytic anemia is well known. In addition autoantibodies against kidney proteins have been blamed for the pathologic changes in chronic nephritis autoanti bodies against liver for the changes in these organs occurring in cases of henatitis and autoantibodies against lens protein and other ove proteins for the syndrome of sympathetic ophthalmia.

#### Summary

An unusual case of Ritter's disease in fraternal premature boy twins is described. The mother of the twins gave a history of poison ivy dermatitis near the end of her pregnancy which was unusual in its severity and in the extensive distribution of the lesions. The hypothesis is proposed that the toxic principle of the plant combined with the mothers skin proteins altering them sufficiently to make them antigenic thus stimulating the production of skin antibodies These antibodies, combining with skin on other parts of the mother's body would account for the extensive distribution of the lesions on her body In addition the antibodice passing through the placenta into the bodies of the twins could also account for the occurrence of the exfoliative dermatitis in them.

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#### J E. KING ESTATE WILLED TO UNIVERSITY

Dr James E. King, 71 years old, who died March 0, left the bulk of his estate valued at between \$200 000 and \$500 000 to the University of Buffalo King, a graduate of the University's School of Medicine, joined its teaching staff shortly after his gradua tion and remained a faculty member until his retirement in 1040

#### NEW HOSPITAL TO OPEN

The X Ray Hospital at 10 Morris Park West Non York City which was closed last September has been sold to a group of negro doctors who will operate it as a private and semiprivate hospital for both white and negro patients

The Hospital can accommodate between 50 and 64 patients.

This was contracted when the moth rof th twins accompenied her hu hand n engineering student during a urvey ing expedition at Bantam, Connectiont. Her husband also contracted by dermatitis but in a mu h milder form.

# CHRONIC PROGRESSIVE BACTERIAL SYNERGISTIC GANGRENE

A I CALIENDO, M D Brooklyn, New York

(From the Norwegian Hospital)

A WHITE man, 37 years of age, in generally poor physical condition with a poor hemic component, was admitted to the hospital with a small penetrating chest wound in the midavillary line of the left chest wall The wound was about 7½ cm long and 5 cm wide, extending into the subcutaneous tissues. No other chest signs or symptoms were present and \rays of the chest were negative on ad-Ten days after admission, the patient began to bleed profusely and intermittently from his wound, from what appeared to be an infected hema-He was taken to the operating room because of the continued profuse bleeding, which had resisted all treatment to stop it

The hematoma was evacuall treatment to stop it ated until healthy tissue presented. The bleeding stopped entirely. It was further treated with hot saline packs and sulfanilamide powder was frosted into the wound

One week following evacuation of the hematoma. the patient started to bleed again from his wound Bleeding and coagulation time taken previously were reported within normal, and further blood studies did not reveal the presence of a blood dyscrasia On examination of the wound, it was found to be grossly infected and had a purplish appearance with thick pus present Further investigation revealed the presence of a large amount of grayish, soft, infected clots Pus and clots were removed for culture as had been done at the previous dressing

The following laboratory report was received from

these cultures

The aerobic culture revealed gram-positive cocci in pairs, clusters, and short chains, staphylococcus aureus, and streptococcus hemolyticus

The anerobic culture had small gram-positive cocci in pairs and long chains, a microaerophilic streptococcus, and some gram-positive bacilli which might be Bacıllı Welchii

This report was thought corroborative of chronic

progressive bacterial synergistic gangrene

Following a blood transfusion of 500 cc of citrated whole blood, the patient was taken to the operating room under general anesthesia The wound was inspected again and found to contain the same soft, gravish blood clots found previously

The edges of the wound were gangrenous with a purplish border and it must be mentioned here that the continuous use of sulfa drugs and penicilinlocally, orally, and by injection—had absolutely no beneficial effect on the wound or progress of the dis-Therefore, a radical excision of the ulcerous wound was done in toto, down to clean tissue and to include a margin of 1 to 2 cm of normal skin. The edges of the wound were undermined for 1/2 to 1 cm All bleeding points were controlled and the wound was packed with a paste of activated zinc perovide, packing it well under the margins of the

A postoperative blood transfusion of 300 cc of citrated whole blood was given the following day and penicillin and sulfadiazine were continued as well as other supportive treatment Blood counts were repeated at intervals and small blood transfusions given until blood count and hemoglobin were within normal limits

Following the operation, this patient's wound stopped bleeding and granulated in uneventfully, so that three weeks later we were able to apply pinch skin grafts, which were successful, and healing was completed. The patient, fully recovered, was fi-nally discharged from the hospital

# WHAT DOES THE MEDICAL SOCIETY OF THE STATE OF NEW YORK DO FOR ITS MEMBERS? The State Journal and Directory

Every member of the Society is entitled to a year's subscription of the New York State Journal of MEDICINE, which presents, in addition to pertinent editorials and scientific articles, sections devoted to personal, hospital, and general medical news, necrologies, and book reviews The Directory gives the names of all doctors engaged in practice in New York, New Jersey, and Connecticut, together with their hospital and society affiliations, lists of accepted hospitals and their staffs, and much additional information of interest to the profession. This work is a standard of references and is widely used for this purpose by various organizations It is more complete in its details than any similar publication

## Medical Society of the State of New York Minutes of the House of Delegates—May 5 to May 7, 1947

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### House of Delegates

### Minutes of the Annual Meeting

May 5 to 7, 1947

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### Morning Session Monday, May 5, 1947

(See 38 47 103 104) Section 8

Annual Report of Malpractice Insurance and Defense Board

To the House of Delegates-Gentlemen

The Malpractice Insurance and Defense Board was created by an amendment to the Bylaws of the Society adopted by the House of Delegates on April 30 1046 Under authority of that amendment the president appointed the following members of the Board

Dr J Stanley Kenney for one year Dr Thomas M D Angelo for two years

Dr James M. Flynn for three years Dr Charles Gordon Heyd for four

Dr Charles Gordon Heyd for four years Dr John F Kelley for five years

Upon the death of Dr James M. Flynn the pressdent appointed Dr Leo F Schiff for the unexpired

As directed by the Bylaws, the following were automatically named as ex officio members of the Board

Dr Walter P Anderton, Secretary of the Society Dr James R. Reuling, Treasurer of the Society Mr William F Martin, Legal Counsel

Mr Harry F Wanvig, Indemnity Representative

At its first meeting the Board elected Dr J Stanley Kenney chairman and Mr Harry F Wanvig, secretary

Four of the original members of the Board, having served on committees on malpractice defense and insurance, were thoroughly familiar with this ac-

uvity of the Society

Policy With Respect to the Consideritial Nature of Information Regarding Suits Lost or Settled out of Court —Since the inception of the Group Plan in 1921 it has been the fixed policy of the Society to discourage publication of any information regarding suits against members which are lost or settled out of court. This policy was reviewed to determine what changes, if any should be made in it. The Board concluded that the publication of any information tending to show that suits against medical men can be recognitive. be successfully prosecuted would only serve to en-courage additional suits and that, therefore, the policy of the Society should be continued without change To give effect to this conclusion, the fol-lowing resolution was adopted by the Board

Wheneas, it is believed that it is not in the best interest of the Medical Society of the State of New York and the general welfare of its mem-bers to permit any publicity as to suits and claims against members which are lost or settled out of

Whereas such publicity can serve no useful purpose but, on the contrary will provoke harm and suffering to the various defendants and will provide ammunition for unfriendly individuals to use against members of the Society

'Now therefore be it resolved, that the relation-ship with respect to such suits and claims, between the insurance company carrying the Group Plan and/or the Society and its members must at

all times be assumed as confidential.

Revision of the Policy Contract With Respect to Cosmetic Plastic Surgery - Believing that some revision of the policy contract was desirable to clarify the exclusion of so-called 'cosmetic plastic surgery the Board adopted the following rewording of the exclusion and requested the Yorkshire Indemnity Company to incorporate the change in the policy contract when a new supply of policy forms is printed

'arising by reason of the performance of any plastic surgical operations except when made necessary by trauma, congenital deformities, or by demonstrable pathologic lesions, and for the sole purpose of improving physical health

Proposal to Establish a Separate Fund to Fur nish Legal Defense for all Members —At the request of the Council the Board made a study of this proposal and returned it to the Council with the follow ing report and recommendations

The purpose of this resolution is to distribute the cost of all legal defense to all members in order to climinate that cost from the operation of the Group Plan of Malpractice Insurance and Defense and thus, reduce the cost of insurance to insured mem-bers. It is pointed out by Bronx County that at present insured members pay the same dues as uninsured members and that some part of their dues is allocated to the defense of uninsured members and that this is inequitable.

After thorough consideration of all the elements involved the Board unanimously agreed to recom mend to the Council that this resolution be dis-

approved for the following reasons

(a) The annual cost of defending uninsured mombers is a relatively small part of the cost of the Society's legal service and thus, absorbs an insignificant part of the membership dues. Therefore, the inequality of the present arrangement if there be any, can hardly be of any real importance to any member

There are in the Society an indeterminate but large number of members who are not in the practice of medicine in circumstances which make them hable to malpractice actions Such members have no need for malpractice insurance or legal defense, yet they pay the same dues as members in private practice and thus contribute to the maintenance of defense service for which they have no need If this resolution were approved, it would penalize such members by increasing their dues to help pay the cost of defense of insured as well as uninsured members This would certainly be inequitable and it is not believed that one inequality should be cured by creating another
"(c) The Society would, if this resolution were

approved, undertake to pay the cost of the defense of suits insured by a private insurance company and the legal counsel is of the opinion that the Society would not be permitted to use any part of its funds

for such a purpose

It is believed that the State Insurance Department would not approve such an arrangement and it is not believed that any reputable insurance company would undertake the Group Plan of the Society on that basis"

This recommendation of the Board was approved by the Council at its meeting on March 13, 1947

Proposal That the Legal Counsel Prepare and Send To the Comitia Minora of Each County Society a Yearly Statement Showing the Number of Members Insured, the Number of Suits and Claims Filed as Be-tween the Insured and Uninsured, the Number Settled Together With the Manner and Cost of Disposing of Them —At the request of the Council the Board made a study of this proposal and returned it to the Council with the following report and recommendations

If approved, this resolution would require setting up in the office of the legal counsel or indemnity representative an additional and entirely new accounting system whose only use would be to furnish In all hability insurance acthe proposed reports counting, suits and claims reported, and the cost of disposing of them are charged against the policy years involved and not against the calendar year in which they are filed or settled. Thus, during any one calendar year, the suits and claims filed and those disposed of pertain to as many as five or six policy years and this system cannot be altered If the need for the information called for by this resolution were great enough, it might be worked out on a state-wide basis at considerable cost information had to be divided between 61 counties the task would be difficult and the expense nearly prohibitive

The Board points out that a report in great detail covering the Society as a whole but in an entirely different form is being furnished the Board annually and has been furnished each year since 1924

There are a number of the smaller counties in which there have been few, if any, suits over a number of years. This fact is meaningless, however, from an insurance standpoint because insurance is based on the law of averages which does not apply to the loss experience of any small group an individual, the loss experience of a small group when considered alone becomes a matter of chance or luck which is a gamble Thus, a small group might have no losses for a long period of time but, on the other hand, it might have one or several losses in quick succession which, insurance wise, would put it in the red for many years Yet, if the lack of suits in the red for many years in any one county were brought to the special attention of the comitia minora of that county, it might create a great deal of unjustified dissatisfaction

Although the representatives of the Bronx County have stated that they do not want the names of the sued members given or identified in any way, it is obvious that detailed information as to suits filed and settled in many of the smaller counties would point unerringly to the doctors involved whether their names were given or not and might do irreparable harm to them in their communities

In the opinion of this Board the most important objection to this proposal is that it would give publicity to the number and cost of suits lost or settled Since the inception of the Group Plan twenty-five years ago it has been the fixed policy of the Society to give out no information whatever concerning such suits to anyone except the members of the Committee on Malpractice Defense and Insurance and officers of the Society After careful consideration that policy was reaffirmed at the first meeting of this Board on October 24, 1946, in the resolution quoted

in paragraph 1 above

After consideration of these factors the Board was unanimously of the opinion that the dissemination of this information would be contrary to the best interests of the Society and recommends to the Council that this resolution be disapproved The board further recommends that if authorized members of any county society desire special information regarding the situation within their own society, applications for such information should be filed with this Board which, in so far as is consistent with the policy of the Society, will endeavor to supply the required data

This recommendation by the Board was approved

by the Council at its meeting on March 13, 1947
5 Annual Audit of the Group Plan—Pursuant to the instructions of the Council and in accordance with the directive of the House of Delegates, the Society's accountants, Messrs Hackeling and Oberkirch, have made an audit of the Group Plan of Malpractice Insurance and Defense, a copy of which was transmitted to the Council

The Board studied the audit and discussed it in detail with Mr Hackeling and Mr Wanvig and offered the following comments regarding it

- Scope The audit covers all the essentials of the Group Plan for the eleven years, January 1, 1936, to December 31, 1946
- Loss Vouchers As directed by the House of Delegates, the accountants made an examination of the loss vouchers This was accomplished by analyzing each voucher and drawing off an independent summary of all of them Spot checks were then made of the original data underlying and supporting a large percentage of them in the office of the Yorkshire Indemnity Company Approximately 1,600 vouchers were involved and amounted to a total of \$1,497,445 42 This total when compared with that reported by our indemnity representative showed a difference of only \$10
- Loss Reserves In the insurance business loss reserves are as much a part of the total loss ex-perience as are the paid losses. These reserves perience as are the paid losses. These reserves which amount to \$943,490 82 are divided into two classes, 1e, those for suits and claims which have been reported but which have not yet been settled, referred to as outstanding, and those referred to as to arise The latter are cases not yet reported but which experience has shown will be filed at some future date for acts committed prior to December 31, 1946, and for which policies issued prior to that date are liable

(b) Outstanding Cases The reserves for these cases are estimated on a case basis by the legal counsel of the Society and the manager of the claim department of the Company The estimates are reviewed four times each year and revised in the light of what is known about each case at that time a result the reserves as a whole for these cases are always adequate and usually produce a saving or salvage which is applied as a credit to the total ro-

serves set up for cases in this category (c) To Arise Cases The reserves for these cases are very difficult to estimate because no one can look forward and determine, with any degree of certainty how many actions will be reported during the next four or five years for acts committed at some time in the past, nor how much it will cost to dispose of them. Nevertheless an effort is made to determine the number of such cases on a mathematical basis by applying to the current policies the ratios of the number of cases which were reported in the past Except in unusual years, this mothod is fairly accu rate as to the number which will arise but in esti mating the money value of these future cases, substantial errors occur However over a period of years the over estimates of good years would nor mally offset the under estimates of high cost years. Due to the recent increase in number and cost of closed cases, these reserves have proved to be in adequate and this factor was largely responsible for the deficit in operations which accrued at the end of While the deficiency in these reserves had been reported to the Board earlier in the year by Mr Wanvig, it was noted and commented on by Mr Hackeling.

Income and Disbursements (a) After a careful study of the audit the Board wishes to point out that it contains matter considerably outside the agreement with the Company under which the

Group Plan is operated

It should be recalled and emphasized that the Group Plan is and always has been an agreement or understanding which provides that the Company will insure the members of the Society under the terms of a master policy issued to the Society as trustee for the members at rates for the minimum limits of \$5,000/\$15 000 based upon the actual losses up to \$5,000 plus predetermined and fixed percentages for operating expenses and profit. That is all the Actna or the 1 orkshire ever agreed to do so far as rates are concerned and that is all the Society has guaranteed to its members.

(c) It is true that the Society exercises a large measure of control over the policy contract, the underwriting practices, the defense of suits and claims, the cost accounting, and computation of rates, but the operation of the Group Plan as an insurance enterprise is, and under the law it must be, a part of the business of the Company While the premiums paid are credited to the operation of the Group Plan they belong to the Company and in no way constitute a fund of the Society Similarly the losses and loss reserves are charged against the opera tion of the Group Plan but they are liabilities of the Company not the Society Thus, while the Society exercises what might be called managerial super vision over the operation of the Group Plan it, as a corporate entity has no responsibility for the funds or liabilities which that operation involves.

(d) The Society may, with propriety have made any kind of an audit which it considers necessary to ascertain whether the terms of the carrying agreement have been lived up to, whether the loss costs have been accurately tabulated, and whether the rates have been correctly computed. That has been done as attested by this audit. However this audit was carried beyond that point and this was made possible by the full cooperation of the Company in supplying the accountants with whatever data they requested But, in doing so the officials of the Company made it plain that they expected the Board and officers of the Society would recognize the confidential nature of some of the information fur nished and that they would treat it accordingly

Underwriting Results (a) The above remarks apply likewise to the underwriting results of the Group Plan referred to as Reservo Excess or

Deficiency

The audit shows that while a substantial deficit occurred in the insurance of losses up to \$5 000 a profit resulted from excess limits. the adjustment of rates for excess limits does not come within the carrying agreement, the lorkshire has felt obligated to reduce the excess rate table whenever the profits from excess limits exceeded what was believed to be a prudent reserve for what might be called catastrophy losses. Two adjustments of that kind have been made in the last eleven years and similar reduction may be expected when ever the situation warrants it.
6 Total Loss Experience The total loss experi

once is found by combining the loss reserves with the paid losses as represented by the vouchers. From the audit the Board finds that the combined total

amounts to \$2,440 936.24.

Conclusion Since the audit could not be distributed to the county societies without violating the confidence of the Company and Jeopardizing the cordial and valuable relations which the Society has with the Company the Board recommended that, in lieu thereof the Council send to the comitia minora of the county societies a report containing the follow ing information

(a) As directed by the House of Delegates, an audit of the Group Plan of Malpractice Insurance and Defense including an examination of the loss vouchers, has been made by independent certified

public accountants

Because the audit was found to contain information which belongs exclusively to the Com pany the Society does not have the authority to

publish it.

(c) The audit has however been carefully studied and found to show that the carrying agreement under which the Group Plan is operated has been fully complied with the loss costs have been accurately tabulated, and the rates have been cor rectly computed as indicated by the following which is quoted from the audit by Mesers. Hackeling and Oberkirch

Your attention is directed to the fact that a \$32 annual premium (on \$5 000/\$15 000 limits) rate is substantially correct for this type of coverage if we

can assume

'A. A continuance of the present high costs of sottling claims and

There is to be no reduction in the deficit sus-В tained to date and

The gain on other types of coverage is not to be considered in establishing rates for the

\$5000/\$15 000 coverage 6 Remsion of Rule as to Effective Date of New Insurance in the Group Plan.—Insurance in th Group Plan is by the terms of the contract, effective at 12 01 A.M. Therefore, insurance negotiated on any given date automatically covers all acts com mitted on that date including those committed prior to ordering the insurance. This amounts to ante dating all insurance as to claims on account of acts committed on the commencement date of the As this could have led to abuses if not corrected, the Board recommended that the Council

[Continued from page 1806]

~	T touchion	Number of Legtures
County	Instruction	Of Pentance
Cattaraugus	General medicine	1
Cortland	General medicine	Ţ
Fulton	General medicine	Ţ
Jefferson	General medicine	Ī
	Pediatrics	1
Madison	Pediatrics	<u>j</u>
	Cancer	1
	General medicine	Ī
	Proctology	7
	Tropical diseases	1
	Obstetrics	1
Nassau	Gynecology	1
Oneida	General medicine	Ī
Onondaga	General medicine	1
Oswego	Proctology	1
Rensselaer	Plasma therapy General medicine	1
St. Lawrence	General medicine	1
	Pediatrics	1
Steuben	General medicine	Ţ
Tioga	General medicine	2 1 1 1
	Gy necology	ī
Ulster	General medicine	1
Wayne	Gynecology	1
Total		24

### REGIONAL TEACHING DAYS

<del></del>		•	Number
		Instruction	Lectures
County	Chemung		
Region	Broome Chemung	Surgery	1
	Schuyler Steuben Tioga Tompkins	General Medicine	2
County	Genesee		_
Region	Genesee Orleans	Gynecology	1
	Livingston Wyo	Plasma therapy	1
	ming	Rheumatic fever— Rheumatic heart disease	1
		Surgery	1
		Tuberculosis	ī
Region-	-Statewide	Obstetrics	1 1
-		Gynecology	1
		Pediatrics	$\frac{2}{2}$
	Meeting	General medicine	2
Teachin	g Day	Surgery	2
Total	_		16

For the year, May 1, 1946, to May 1, 1947, the Committee on Public Health and Education, with the cooperation of the New York State Department of Health, arranged for instruction to be presented in 38 counties with a total of 174 lectures

Arrangements have been made for instruction to be given in the near future in the following counties Cayuga, Cortland, Nassau, Oswego, Rockland, St Lawrence, Saratoga, Schenectady, Seneca, Sullivan, Tioga, and Tompkins

Arrangements have also been completed for instruction to be given in the fall in Cayuga, Cortland, and Oswego County medical societies

Clinton County has indicated a desire for a series

of lectures to be given in the fall

The following Regional Cancer Teaching Days will be held in the near future

		Date of Meeting	Number of Lectures
County Region	Broome Broome Chemung Chenango Cortland Dela ware Otsego Schuyler Tioga, Tompkins	May 14 1947	5
County Region	Queens Kings Nassau Queens Suffolk	May 16 1947	6

A request was received from the Otsego County Medical Society to arrange for a Regional Teaching Day to be held sometime in June, 1947

A Teaching Day on Obstetrics and Gynecology will be arranged for the Suffolk and Nassau County

medical societies to be held October 1, 1947

A request has been received from the Monroe County Medical Society to arrange a teaching day to be held the second week in November, 1947

Section 10 (See 57)

Supplementary Report of the Council—Part II Maternal and Child Welfare

At the request of the New York State Department of Health, a conference of the Council Committee on Public Health and Education, and the Committee on Maternal Welfare was held in New York City on April 9, 1947, to discuss the development of a colored film library to be available for speakers in post-graduate instruction Dr Edward C Hughes, graduate instruction member of the Committee on Maternal Welfare, was requested to obtain information regarding subjects to be considered for color films and to inquire about films being produced by the nine medical schools in the State Present at this conference, in addition to the Committee members, were some of the officers of the Medical Society of the State of New York and representatives of the New York State Department of Health

Section 11 (See 58)

Supplementary Report of the Council-Part IV Public Health Activities

BCG Immunization —The President of the Medical Society of the State of New York designated tentatively the following physicians as members of the Advisory Committee on BCG to the Council Committee on Public Health and Education and the New York State Department of Health

Milton I Levine, M.D., Chairman, 1111 Park Avenue, New York 28 Edith H. Lincoln, M.D., 660 Park Avenue, New

York

James R Reuling, M D, 217-06 40th Avenue, Bayside

Robert A Ullman, M D, 1171 Delavan Avenue, Buffalo

At the meeting of the Council of the Medical Society of the State of New York on March 13, 1947, it was voted that the above members as designated by

the President, be approved

The New York State Department of Health also nominated four physicians as members of the BCG

Advisory Committee

Robert E Plunkett, M D, assistant commissioner for tuberculosis control, Division of Tuberculosis control

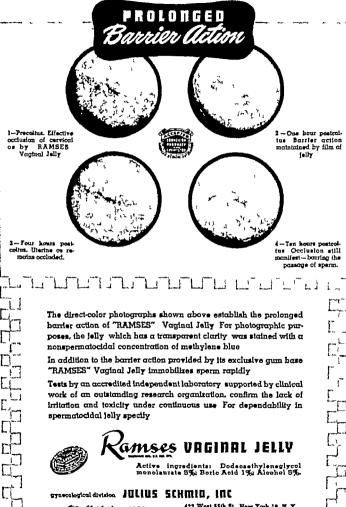
Julius Katz, M D, Division of Tuberculosis Control

Gilbert Dalldorf, M.D., director, Division of Laboratories and Research

Konrad Birkhaug, M.D., Division of Laboratories and Research

Meetings of the BCG Advisory Committee were held in New York City on March 12 and April 19, As a result of these conferences, the following Preliminary Report Subject to Later Minor Revisions was submitted by the Chairman, Dr Levine Present at these conferences, in addition to the members of the Advisory Committee, were members of the Council Committee on Public Health and Education, some of the officers of the Medical So-

[Continued on page 1810]



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[Continued from page 1808]

ciety of the State of New York, and representatives of the New York State Department of Health

Preliminary Report Subject to Later Minor Revisions of the Advisory Committee on BCG Vaccination to the Medical Society of the State of New York and the New York State Department of Health

### Status of BCG Vaccine

(a) Safety On the basis of over 5,000,000 vaccinations throughout the world it has been established that BCG vaccine, properly cultured and controlled,

is harmless

The vaccine, (b) Reactions from Inoculations when administered in the manner advised (by the multiple puncture method, by scratch, or intracutaneously) produces a local lesion which at the most leaves a scar resembling that of vaccination against smallpo. In a certain number of instances of intracutaneous inoculation, suppuration of the lymph nodes draining the area may result which subsides in a few weeks Such a result, however, is probably due to subcutaneous rather than intracutaneous inoculation No fever is associated with the reaction and no pain or disability

(c) Effectiveness of BCG vaccine Experimental studies on human beings seem to indicate that the vaccine, properly cultured and used, is effective in

the prophylaxis against tuberculosis

### Preparation of BCG Vaccine

In order to have uniform material and controlled distribution there should be one central laboratory (the New York State Department of Health is suggested) for the preparation and distribution of BCG vaccine in New York State

(b) The lot number as well as the date of expira-

tion must be placed on each vial of vaccine

The vaccine is to be tested regularly in the (c) central laboratory for virulence, potency, and free-

dom from contamination

The concentration of BCG vaccine differs with the mode of vaccination A lower concentration (10 mg/ML) is used in the intracutaneous method than in the multiple puncture or scratch method, where 20 mg/ML is used Therefore, the BCG vials should be clearly distinguishable as to concentration of vaccine contained

### Recommendations on the Use of BCG Vaccine

(a) Only tuberculin-negative persons are to be

(b) In determining tuberculin sensitivity it is advised that only the intradermal tuberculin test be used with either dilute old tuberculin or preferably purified protein derivative

Uniform procedure recommended for tuberculin testing

When a purified protein derivative is used 0 00002 mg should be the first testing dose and 0 005 mg the second. When old tuberculin is used, a first test of 0 01 mg should be employed If this is negative. 0 1 mg should be injected as a second test

Tests are to be read forty-eight to seventy-two

hours

Roentgenograms of the lungs should be made (c)

at time of skin testing

(d) The BCG vaccine is to be administered by the scratch method, intracutaneously, or preferably by multiple puncture

Oral and subcutaneous methods are not to be used In the intracutaneous inoculation the recommended dosage is 0.1 mg of the standard product

(e) If at all possible, vaccinated persons should be prevented from coming in contact with open cases of tuberculosis for six to eight weeks after vacci-

All vaccinated persons should be tuberculin **(f)** tested two months after vaccination and every two Tuberculin negative persons thereafter years

should be revaccinated.

Each vaccinated individual should have in his possession a statement that he has been vaccinated This statement should be shown to any physician consulted thereafter

Standard records furnished by the State Department of Health are to be filed for each patient

vaccinated

### Distribution of BCG Vaccine

The distribution of BCG vaccine should be limited for the present to (1) medical colleges, (2) superintendents of public tuberculosis hospitals and directors of tuberculosis clinics and (3) selected additional hospitals and institutions under supervision of specially trained doctors who have been designated by the Commissioner of Health of the New York State Department of Health

The vaccine is recommended for use (1) where there has been a known exposure to tuberculosis or where an exposure is likely to occur, (2) in groups occupationally exposed (e.g., nurses and medical students), and (3) in selected population groups with high tuberculosis morbidity and mor-

tality\_rates

Education Concerning BCG

(a) Professional groups The education of physicians and nurses concerning BCG is to be given by physicians experienced with BCG

(b) Public education Education of the public should be under the New York State Department of

Health and the local health authorities

### BCG Administration

There should be a central administrator for BCG immunization control in the New York State Department of Health, Albany, New York
It is recommended that the duties of the adminis-

trator include the following

(a) Control the production and distribution of BCG

Assume responsibility for education of physicians as well as the public concerning its use

Keep the records and all reports necessary

regarding the BCG inoculations

(d) All records of BCG moculations are to be kept in duplicate, one for the administrator in Albany and the other to be retained locally

This administrator is to be responsible to the Assistant Commissioner for Tuberculosis Control of the New York State Department of Health

Mental Hygiene -On March 29, 1947, in New York City, a meeting of the Council Committee on Public Health and Education and the Subcommittee on Mental Hygiene was held Present at this conference, in addition to the Committee members, were some of the officers of the Medical Society of the State of New York and the Commissioner of Mental Hygiene in New York State It was agreed, time permitting, that a preliminary report regarding the mental hygiene program in New York State would be presented to the House of Delegates

Training and Licensing of Physiotherapists in the State of New York.—The following communication addressed to Dr W P Anderton, Secretary, Medical Society of the State of New York, was read at the

[Continued on page 1812]

What does S-M-A stand for?



5-M-A ? A certain baby (wise beyond his years) explains those in triguing letters. "Sure Merits Approval."

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S-M-A



[Continued from page 1810]

meeting of the Council of the Medical Society of the State of New York on February 13, 1947

The University of the State of New York The State Education Department Albany 1 New York

February 6 1947

Dr W P Anderton 292 Madison Avenue New York, N Y Dear Dr Anderton

Dear Dr Anderton

I am writing to you as Secretary of the Medical Society to express my concern with respect to the training and licensing of physiotherapists in the State The physiotherapy law, as you know requires four years of training which is more or less equivalent to the training expected of a physician The law also provided a grandfather s clause which resulted in the admission to the profession of physiotherapists variously trained prior to the effective date of the law As a result we have in the profession at the present time a considerable number who did not have, in all respects satisfactory education and training Moreover because of the high requirements of the law we have not licensed any physiotherapists since the law went into effect Because of the high standards we have been unable to register a single school of physiotherapy in the country

On the other hand we have a number of institutions training so-called physical therapy technicians. These technicians are serving the medical profession and are in my opinion practicing physiotherapy without a license. This has resulted in my opinion in a thoroughly unsatisfactory situ-

I am writing to suggest that the Medical Society appoint a committee to make a study of this entire problem. I would hope that the committee would consult the physicians and arrive at a program of study which would be satisfactory to them. I am not convinced that this program of study should be or that it needs to be four years in length even for those who start with no professional or even allied training. It would seem altogether possible to take graduates of physical education schools and graduates of schools of nursing and give them a course of training of one or two years duration and thereby turn out a product which would meet the needs of the medical profession and the people of the State.

I would be pleased to have your reaction to my suggestions and if I can be of any service in connection with this problem. I would hope that you would feel free to call upon me ation

With kind regards I am

Cordially yours

/s/ J HILLIS MILLER

After discussion, it was voted to refer this matter to the Council Committees on Public Health and Education, and Legislation

On April 9, 1947, in New York City, a joint meeting of the Council Committees on Public Health and Education, and Legislation was held to consider the problem of training and licensing of physiothera-pists in New York State A recommendation, that a carefully chosen Subcommittee of the Council Committees on Public Health and Education, and Legislation who are familiar with physiotherapy be appointed to make a study and to submit a report within the next few months, was submitted to the Council on April 10, 1947 This recommendation was approved by the Council and the Subcommittee will be appointed by the president at the next meeting of the Council

> Respectfully submitted O W H. MITCHELL, M D, Chairman Council Committee on Public Health and Education

April 24, 1947

Section 12 (See 108)

Annual Report—Part VI Annual Report—Part VI Joint Committee of the Hospital Association of New York and the Medical Society of the State of New York

The Joint Committee of the New York Hospital Association and the Medical Society of the State of New York was composed of the following personnel

Medical Society

Carlton E Wertz, M.D., Chairman, Buffalo Walter W. Mott, M.D., White Plains J Stanley Kenney, MD, New York

Hospital Association

Hon Lee B Mailler, Chairman, Cornwall Morris Hinenburg, M.D., Brooklyn John F. McCormack, New York Moir P Tanney, Buffalo Carl P Wright, Syracuse

On December 5, 1946, Dr Wertz was instructed by the Council to transmit to this Committee the objection of the Medical Society of the State of New York to having medical services included in any contract between hospitals in New York State and

the US Veterans Administration

At a meeting of the Committee in the State Society office on December 30, 1946, Drs Wertz, Mott, Kenney, and Anderton represented the State Society, and Mr George P Farrell, Director of the Bureau of Medical Care Insurance, and Dr David J Kaliski, Director of Workmen's Compensation Bureau, were present The New York State Hospital Association was represented by Dr Hinenburg, McCormack, and MacDermott Messrs Rhoderick Wellmans, counsel for the Hospital Association, and Dr. M. J. Fein, secretary of the Joint Council of Radiologists, Pathologists, Anesthesiologists, and Physical Therapy physicians were present There was considerable discussion regarding proposed legislation to label the practice of radiology, pathology, anesthesiology, and physical therapy by physicians as part of the practice of medicine

On January 31, 1947, a similar meeting was held There was agreement upon the principle that the practice of any of these four specialties is the practice of medicine A bill naming the practice of radiology in this category was introduced in the legislature,

but was not passed.

It is hoped that this Joint Committee will be continued in order that conferences between the hospital association and the Medical Society may proceed to the formulation of legislation which will be mutually acceptable

Section 13 (See 65)

Supplementary Report of the Council-Part VII Public Relations and Economics

To the House of Delegates—Gentlemen

The Council Committee on Public Relations and Economics submits the following supplementary

At a meeting of the Subcommittee on Medical Expense Insurance of the Council Committee on Public Relations and Economics, April 4, 1947, standards of approval of New York State medical care plans by the Medical Society of the State of New York were drawn up and approved by that committee These standards are proposed as a protection to the medical profession in regard to the method of medica care plan operation and the distribution of medica services to the plans' subscribers, and are comparable to those standards adopted by the Council on Medical Service of the American Medical Association Recommendation was made that these standards be submitted to the Council of the Medical Society of the State of New York for approval

A recommendation was made at the Council meet mg, April 10, 1947, that the standards be presented to the House of Delegates for study and action The standards as approved by the Subcommittee are

submitted herewith

[Continued on page 1814]

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### [Continued from page 1812] Standards

Local Approval

1 Approval of the county medical societies in

whose area it operates

2 In the event a county society does not approve a plan, a special committee of three members be appointed, one by the plan, one by the county medical society, and one by the Medical Society of the State of New York, to investigate and study the reasons why approval was withheld

3 If it is the opinion of a majority of the committee, approval will be granted to the plan after

consideration

Professional Control

1 The Board of Trustees must contain a majority of physicians
2 That these representatives shall be members

2 That these representatives shall be members of the Medical Society of the State of New York 3 The medical profession to assume responsi-

3 The medical profession to assume responsibility for the medical services included in the benefits

Free Choice of Physician

I There shall be no regulation which restricts the choice of a qualified doctor of medicine in the locality covered by the plan, who is willing to participate and render service under the conditions established

2 The method of rendering the service must retain the personal, confidential relationship between

the patient and the physician

Subscriber Benefits

Subscriber benefits may be in terms of cash and/or service units

Claim Payments

1 When care has been rendered by a participating physician and claim filed for such care, payment shall be made direct to the participating physician When subscriber has paid the physician, then payment may be made to subscriber upon presentation of a receipted bill. This method of payment should be discouraged and should apply only in instances where subscriber has paid the physician

where subscriber has paid the physician

When care has been rendered by a nonparticipating physician and claim filed for such care, payment shall be made direct to the nonparticipating physician or to the subscriber upon presentation of

receipted bill.

Underwriting

1 Subscriber premium rates should be adequate to provide for the benefits offered and the risks involved in the contract

2 Plan should be organized and operated to provide the greatest possible benefits in medical care to

the subscriber

3 All plans shall conform with state statutes as set up under the New York State Insurance Department with due consideration for earned premiums, administrative costs, and reserves for contingencies Enrollment

Enrollment procedures shall be on a sound basis so as not to expose the plan to adverse selection

It is recommended that enrollment be offered to individuals at the earliest possible date that experience of the plan warrants

### Promotion

Descriptive folders and all promotional material will state clearly and accurately the benefits offered by a plan, and, also, in the same manner, exclusions in the contract

Reports

All plans which have received approval, or are seeking the approval of the Medical Society of the State of New York, shall submit quarterly reports on forms provided for that purpose, to the Bureau of Medical Care Insurance of the Medical Society of the State of New York

Duration of Approval

Approval by Medical Society of the State of New York shall be for a period of one year, at the end of which, review of all plans will be made by an appropriate committee of the Medical Society of the State of New York, to determine eligibility for renewal

Respectfully submitted, CARLTON E WERTZ, M D, Chairman Council Committee on Public Relations and Economics

Section 14 (See 97)

Supplementary Report of the Council—Part IX Legislation

To the House of Delegates-Gentlemen

The Council Committee on Legislation respect-

fully submits a supplementary report

The 1947 session of the New York State Legislature was one of the shortest sessions but one of the busiest. The Legislature convened this year on Wednesday, January 8, and adjourned on Tuesday, March 18. In that short period of time a record number of bills was introduced. There were 2,557 bills introduced in the Senate and 2,756 bills introduced in the Assembly, or 5,313 bills. Besides this record number of bills introduced, there was a record number of bills amended and many resolutions introduced.

The Legislative Committee was interested in following 119 bills in the Senate and 143 bills in the Assembly, in all, 262. As 105 of these bills were concurrent, this would mean that we were interested in 157 separate bills. Of the 157 bills in which we were interested, 114 were defeated in committee or not reported out by the end of the session, 43 passed both houses and were sent to the Governor. Thirty-three of these bills were thirty-day bills on which the Governor had thirty days, or until April 17, to take his final action. Of these 43 bills, the Governor has signed 35 and has vetoed 8

Among the bills that were defeated or not reported out of committee were the Farbstein compulsor, health insurance bill and the two Senate and the two Assembly bills which would set up licensure for the practice of chiropractic. The opposition registered by members of the medical profession and their friends against the bills for the licensure of chiropractic no doubt had a good deal of influence in preparation these bills having reported out of committee.

venting these bills being reported out of committee. As there was no bill introduced this year to prevent vivisection, we were not called on to campaign against such bills as in former years. A bill was introduced this year which would extend to the whole State of New York the provisions already applying to New York City relating to the stealing of dogs. The Legislative Committee registered no opposition to this bill and it was passed and became Chapter 345 of the Laws of 1947. There was also introduced in this session a bill to amend the Penal Law in regard to scientific tests on living animals. This bill provides that scientific tests on living animals shall be conducted in laboratories or institutions approved by the State Health Commissioner and subject to inspection of laboratory and to

[Continued on page 1816]

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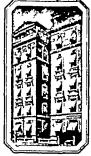
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[Continued from page 1814]

standards fixed by the Commissioner for a certificate of approval The Legislative Committee did not go on record as being either in favor of or opposed to this bill. This bill was passed and signed by the Governor and became Chapter 408 of the Laws of 1947

At the request of the Medical Grievance Committee, the Legislative Committee had introduced in the Senate and Assembly a bill to amend the Education Law authorizing revocation, suspension or annulment of license, and registration of a medical practitioner for newspaper advertising for patronage. or for having been addicted to the use of drugs This amendment to the Education Law was proposed by the Grievance Committee The Grievance Committee was of the opinion that this amendment would strengthen and improve that section of the Education Law dealing with disciplinary procedures and that this change was necessary in view of their experience in handling such cases. The same bill was introduced in the Senate and Assembly. This bill passed the Senate but was defeated in the Assembly Education Committee, where the bill was amended removing that portion pertaining to newspaper advertising for patronage The amended bill in the Assembly was passed by that house and also by the Senate, and signed by the Governor It be-came Chapter 518 of the Laws of 1947 It is regrettable that the bill was not passed as introduced. as the restriction against newspaper advertising was thought to be very desirable. At the present time the best newspapers do not accept such advertising, only the newspapers that are essentially a local advertising medium and foreign-language newspapers make a practice of taking advertisements for physicians for the gain of patronage As all forms of advertising for gain of patronage have been considered unethical—and other forms such as advertising by radio, cards, posters, magazines, etc., are illegal—it is regrettable that this bill did not make it illegal for

advertising in newspapers also

The Legislative Committee, after studying the three bills that were introduced in this session to permit physicians to practice as partners or in groups to share fees and to contract with a nonprofit medical indemnity or hospital service corporation to practice medicine on its behalf for persons insured under its contracts or policies, was of the opinion that there were grave dangers to the public should these bills be At the meeting of the legislative chairmen of the county medical societies these bills were also unanimously opposed In view of the action by the County Society legislative chairmen and the State Legislative Committee, strong opposition was registered with the Governor even after these bills had passed both houses There was a difference of opinion among the medical profession on these bills and certain groups of the medical profession were supporting them A more lengthy discussion of these bills has been given in the preliminary report and also in the bulletins sent out by the Legislative Committee. Two of these bills—Senate Int 740 and Senate Int 741—were signed by the Governor and became Chapters 722 and 721, respectively (Laws of 1947) The third bill—Senate Int 742—was vected by the Governor Had this bill been around by the Covernor the result of the Senate Int 740. signed by the Governor the prohibition against advertising the practice of medicine would have been removed for those persons constituting a partnership or group of physicians who have an agreement with a nonprofit corporation created under Article 9-C of the Insurance Law to provide medical care for inthere was a great possibility of undesirable advertising developing should this amendment be enacted, and it was gratifying to the Legislative Committee that the Governor vetoed this bill.

that the Governor vetoed this bill.

The Turshen bill—Assembly Int S98—which was reported in the preliminary report, which would have permitted partnerships of physicians maintaning a common office and which was supported by the Legislative Committee and the legislative chairmen of the county medical societies, was not reported out of committee. The same fate befell the Clancibil which defined v-ray diagnosis as the practice of medicine and prohibited any person other than a medical practitioner, dentist, or chiropodist from diagnosing fluoroscopic or registered shadow of any part of the body, or from using v-ray or radium for treating human ailments

The bill which would have permitted the establishment of medical bureaus by a group of employers, and to which the Legislative Committee was opposed, was vetoed by the Governor We were not as successful in our opposition, however, to the bill Assembly Int 2712, which makes valid claim of laboratory or voluntary hospital bureau for services in connection with x-ray examination, diagnosis, or treatment of claimant to workmen's compensation. It is understood that this bill had strong support from the Labor Department and was signed by the Governor and became Chapter 766 of the Laws of

All podiatry, optometry, and physiotherapy bills that were introduced this year either were defeated in committee or were vetoed by the Governor. The very lengthy bill amending the Education Law generally, and which was passed by both houses, has been signed by the Governor and became Chapter 820 of the Laws of 1947. This bill revises the Education Law without substantive change. It is to become effective July 1. Under this amendment the Medical Practice Act, which was formerly Article 48 of the Education Law, becomes Article 131. It now has the title "Medicine, Osteopathy, Physiotherapy" instead of the former title "Practice of Medicine". The sections under this article which were formerly 1250–1266, now become sections 6501–6517.

The Legislative Committee, in submitting this final report, again calls attention to the large number of bills which were introduced in this session of the Legislature which were of primary importance to the medical profession. Although it cannot report that all bills were passed in which we were in favor, nor all defeated to which we were opposed, in a general way the acts by the Legislature this year have been along the lines advocated by the profession and the Legislative Committee

This legislative session has impressed the Legislative Committee of the great need for continual attention to legislative matters both on the part of every member of the profession and every citizen. There has been a gradual change in legislative matters as shown both in the State Legislature and in Congress. Minority pressure groups are having the greatest effect which can only be combated by the interest of the individual voter and his contact with his representatives in these bodies. The legislators themselves would appreciate nothing more than to have this interest shown by their own constituents.

The Legislative Committee will make every effort to keep the members of the State Society informed on legislative matters which are of interest to the medical profession, with the hope that the State Society will continue to occupy its important place as

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[Continued from page 1816]

an adviser to the Legislature and to the Governor on matters pertaining to the public health and the public good

Respectfully submitted, HARRY ARANOW, M D, Chairman Council Committee on Legislation

Section 15 (See 18, 126)

Supplementary Report of the Council Committee— Part X Workmen's Compensation

The Chairman of the Workmen's Compensation Board, under the authority vested in her under Section 13-a and Section 141 of the Workmen's Compensation Law, promulgated the following partial revision of the medical fee schedule, in response to the request of the President of the Medical Society of the State of New York for an increase in the said schedule

The revision includes the first eight items of the proposed schedule covering office, home, and hospital calls, consultation of practicing physician with

specialist

The new schedule shall be applicable to medical care in new cases arising after June 1, 1947, and to old cases reopened and retreated after that date. The discount of 5 per cent heretofore permitted for payment of medical bills of \$15 or over is abolished.

It has been estimated that the revision so far promulgated will include about 60 per cent of all patients treated under the Workmen's Compensa-

tion Law

The remainder of the schedule will receive the attention of the advisory committee appointed by the Chairman of the Workmen's Compensation Board within the next few weeks, and it is hoped a revision upward of the remainder of the schedule

will be announced at an early date

The Chairman of the Workmen's Compensation Board has requested the 23,559 physicians who are authorized to treat compensation cases in this State to give more attention to the prompt filing of reports in order to facilitate the administration of the Workmen's Compensation Law. The department will hereafter more rigidly enforce the rules concerning reporting. Hereafter, if a physician fails to report a case within the time limits prescribed by law, it will be necessary for him to submit with the tardy report a notarized statement giving the reasons for the late filing and asking to be excused from the penalties provided in the Law for failure to report on time

Hereafter, where a patient's complete treatment does not involve more than forty-eight hours' care it will not be necessary to file a C-104 report, but a C-4 report may be filed, and marked "Final," by the

attending physician

Rating M-17—Dr Louis Bauer, President, conferred on May 1, 1947, with Miss Mary Donlon, Chairman of the Workmen's Compensation Board with reference to the rating of M-17 (thoracic sur-

gery) She is not satisfied as to the advisability of setting aside this rating for thoracic surgery. She has requested further data and information from the State Society

Resolutions by County Societies Re Fee Schedule—Recently as the result of action taken by various county medical societies, following the passing of resolutions by Albany County, to the effect that after May 15, 1947, they will submit bills in compensation cases in accordance with the proposed fee schedule, the Chairman of the Workmen's Compensation Board advised the Albany County Medical Society that they had no authority to devise or promulgate a fee schedule, and that the payment of fees by employers and carriers in excess of the minimum, except under extraordinary circumstances, would be unlawful A letter of instructions was issued by Miss Donlon to the insurance carriers informing them that the payment of fees in excess of the minimum, except when extraordinary service was demonstrated, is unlawful

We do not agree with this statement, nor do we

find any warrant in law for such action

Re Rating of Physicians in Employ of State—We have had no opportunity as yet to meet with Miss Donlon and discuss with her the position she has taken in refusing to authorize and qualify physicians in the employ of the State of New York

The Commissioner of Mental Hygiene has expressed his approval of said employed physicians (in the Department of Mental Hygiene) examining

and treating compensation claimants

The position taken by Miss Donlon deprives a number of rural counties in the State of the services of qualified psychiatrists and pathologists, in some of these areas they are the only qualified specialists in these branches

Maurice J Dattelbaum, M D, Chairman David J Kaliski, M D, Director

WORKMEN'S COMPENSATION FEE SCHEDULE-MAY 1947

	Proposed Fee			
New No	Schedule Number		Amount Allowed	Amount Proposed
1 2	50 51	First office visit Subsequent office	\$3 50	\$5 00
3	49	visits First visit—house	2 50	3 00
4	52	call Subsequent day home	5 00	6 00
5	53	call Subsequent house	4 00	4 00
6	54	calls 10 P M -7 A M Hospital call—day	6 00 2 50	6 00 3 00
7	54-a	Hospital call 10 PM -		5 00
8	55	Consultation of prac- titioner with spe-	0 00	0 3-
Ru	le 21 5 p Abo	cialist er cent discount on b blished	5 00 illo of \$1	5 OU 5 or over

### NECROLOGY

Charles Rodgers Conklin, M.D., 73 of New York City, died on July 7 A former director of the Chil dren's Aid Society's medical department Dr Conk

lin retired in 1910

Dr Conklin received his medical degree in 1899 from Albany Medical College and was graduated in 1901 from the New York Homeopathic Medical Col lege. He was instrumental in establishing the Mil bank Home for Convalescent Boys at Valhalla, and the Elizabeth Milbank Anderson Home for Con valescent Children, Chappaqua. He was a member of the American Medical Association and the State and County medical societies

Thomas H. Farrell, M.D., 78, of Utica, died on June 28 Dr Farrell was a former vice-president of the Medical Society of the State of New York, a member of the American Academy of Surgeons American Laryngology, Rhipology, and Otology Society Academy of Medicine, American Medical Association, and the State and County medical

societies

He was consultant to Marcy State Hospital and affiliated with the department of ophthalmology and otolaryngology at Faxton Hospital Utica. Farrell received his medical degree in 1895 from Queens University Faculty of Medicine, Kingston

Canada.

William Young Finch, M.D., of Manhasset and formerly of Brooklyn, died on June 29 He was graduated from the Columbia University, College of Physicians and Surgeons in 1897 Dr Finch was a member of the American Medical Association, and the State and County medical societies. Until the date of his retirement, Dr. Finch had been a member of the Kings County Medical Society for fifty years

He was 75 years old George Munroe Goodwin, M D, of New York City died on July 12 at the age of 60 He was gradu ated from Columbia University College of Physicians and Surgeons in 1911 Dr. Goodwin was director of medicine at St Luke s Hospital, New York City chief of the thyrold clinic at St Luke s out patient department, and attending physician at the New York Orthopedic Dispensary and Hospital He was a member of the American Medical Associa tion New York State and County medical socioties American College of Physicians, New York Academy of Medicine, and a diplomate of the American Board of Internal Medicine.

Mark Heiman, M.D., 71 Syracuse dermatologist and former president of the American Academy of Dermatology died on July 2. He was graduated from the Syracuse University School of Medicine in 1897 and was a former president of the Central New York Dermatological Society former president of the Byracuse Academy of Medicine, and past chairman of the Dermatology Section of the Medical Society of the State of Now York. He was senior dermatologist and ayphilogist at St Joseph a Hospi tal in Syraouse

Dr Heiman was a member of the American Medi cal Association, the State and Onondaga County medical societies and dermatologist at the General

Hospital of Syracuse

John L. Kantor M.D , 57 of New York City gastroenterologist and associate clinical professor of medicine at Columbia University, College of Physicians and Surgeons, died on June 26
He served in both World Wars and during World

War II held the rank of colonel in command of the

19th General Hospital He was graduated from Columbia University, College of Physicians and Sur

geons in 1912

From 1919 to 1935 he was chief of clinic for gastrointestinal diseases at the Vanderbilt Clinic. At the time of his death he was gastroenterologist and associate roentgenologist of Monteflore Hospital, New York City, gastroenterologist for Beth David Hospital New York City, and a consultant for the Will Rogers Hospital at Saranac Lake the National Jewish Hospital in Denver and Sharon Hospital at Sharon Connecticut

Dr Lantor was a member of the American Roent gen Ray Society American College of Physicians American Gastroenterology Association Academy of Medicine New York Castroenterological Association Association of Military Surgeons American Medical Association and the State and County

medical societies

Jerome J Klein, M D., 34 of Now York City died on April 19 He was graduated from George-town University Medical School in 1937 A member of the New York Cardiological Society the American Medical Association, and the State and County medical societies Dr Klein was cardiologist at the Stuyvesant Poly clinic Hospital and associate visiting physician at the Gouverneur Hospital in New York City

Theodore Kuttner, M.D., of New York City died on July 7 at the age of 70 Dr. Kuttner who developed the Kuttner Leitz micro-colorimeter for blood analysis, was an associate chemist on the staff of Mt Sinai Hospital New York City

He was graduated from New York University and Bellevue Medical School in 1900 and lectured on pathologic chemistry at Columbia University from 1922 to 1925 For twelve years he conducted research in pathologic chemistry through the Blumen thal Fellowships of Mt Sinai Hospital He was a member of the American Medical Association, the State and County medical societies and the American Chemical Society

Joseph J McGarry M D., 51 of North Tarry town, died on June 30 He was graduated from Fordham University Medical School in 1918 more than twenty years he contributed his services to the St Vincent De Paul Institute, a Catholic children's institution at Tarrytown.

Dr McGarry was a member of the American Society of Anesthetiste the American Medical Associety of Anesthetiste the American Medical Association (Medical Association) clation, and the State and County medical societies

He was an anesthetist at the Tarrytown Hospital.
Frederick M Miller, M D., 77 of Binghamton surgeon in-chief of the Binghamton City Hospital since 1917 died on July 9 Dr Miller was graduated from New York University College of Medicine, in He was a member of the American Medical Association, a permanent member of the Medical Society of the State of New York a fellow of the American College of Surgeons, a former president of the sixth District Branch He was a former presi dent of the Broome County Medical Society and surgeon to the Erio Railroad in the Binghamton area.

John H Schall, M.D., 75 of Brooklyn died on July 10 He had been chief consulting surgeon for thirty years at the Prospect Heights Hospital and a founder and chief surgeon from 1914 to 1915 of the

Cumberland Hospital in Brooklyn.

[Continued on page 1820]

### NECROLOGY

[Continued from page 1819]

Dr Schall obtained his medical degree in 1893 from Hahnemann Medical College, and was the author of numerous medical books He was a member of the American College of Surgeons, the International College of Surgeons, the American Medical Association, and the State and Kings County medi-

Alfred Schwab, M D, of New York City, died on July 13 at the age of 71 He was graduated from Columbia University, College of Physicians and Surgeons, in 1895, and had practiced in New York City for fifty years

Mary L H A Snow, M D, of Windham, died on July 11 at the age of 80 She received her medical degree in 1897 from Cooper Medical College, Stanford Havronsity, Colloguia and was a member of the

ford University, California, and was a member of the American Congress of Physical Therapy and the American Academy of Physical Medicine

Isadore Steinman, M D, 58, of the Bronx, died on June 24 He was a graduate of Columbia University, College of Physicians and Surgeons, in 1918, and was a member of the American Medical Association and the State and Bronx County medical

societies

Charles J Tomer, M D, of Corning, died on November 5, 1946, at the age of 82 He was a graduate of New York University, College of Medi-cine, in 1887 He was formerly connected with the Steuben Sanitarium in Hornell, and served as Corning physician and Steuben County coroner Benedict Vogt, Jr, M D, of Queens, died on De-cember 23, 1946 He was graduated from the Long

Island College Hospitol in 1906 Dr Vogt was a member of the American Medical Association, the State and County medical societies, and had been

assistant physician and assistant allergist at the Lutheran Hospital in New York

Walter E Vogt, M D, 66, of Brooklyn, attending gynecologist on the staff of Bushwick Hospital, Brooklyn, died on June 28 He was graduated from Cornell University Medical College in 1903, and was a more of the State and Kings County medical a member of the State and Kings County medical

societies and the American Medical Association Herbert T Wikle, M D, 53, of Brooklyn, director of surgery at Cumberland Hospital, Brooklyn, died

on June 26

He was graduated from Vanderbilt University, School of Medicine, in 1919 In 1922 Dr Wikle was assistant clinical professor of surgery at the Long Island College of Medicine At the time of his death he was consulting surgeon at Methodist Hospital, and Bay Ridge Hospital, and attending surgeon at Brooklyn Hospital Dr Wikle was past-president of the Brooklyn Surgical Society and the New York Gastroenterological Society He was a member of the American College of Surgeons, the American Medical Association, and the State and Kings County medical societies

David Zuckerman, M.D., of Brooklyn, died on January 24 at the age of 60. A graduate of New York University and Bellevue Hospital Medical College in 1910, Dr. Zuckerman was a founder, member of the board of directors, and chief proceed to the Communication of th

tologist at the Crown Heights Hospital

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The membership of the National Mental Health Foundation, incorporated one year ago, has grown to nearly 3000 according to a roport issued by Harold Barton, executive secretary on the occasion of the Foundation's first birthday

In the year of its existence the Foundation has reached out into many states to cooperate with dozens of existing mental hygione groups, and church organizations, in a drive to enlighten the public on the proper care and treatment of the mentally ill. It has supplied an impotus to effect legislative reforms for improvement of the administration of state mental health programs and has been instrumental in publicing nationally the evils that exist in state hospitals for the mentally Those cvils were uncovered by a survey which produced the largest body of facts over gathered together on the subject of the nation s treatment of victims of mental disorders.

From a small group of organizational workers a year ago, the Foundation has grown to a staff of thirty full-time workers and a host of volunteers in communities throughout the country. They prepare and distribute educational material designed to interpret the problem of mental health to the layman in such language as to clarify a subject hitherto belogged by obscure professional terminology as well as to change the public attitude toward mental disease from one of dread to understanding and helpful sympathy -Westchester Medical Bulletin June 1947

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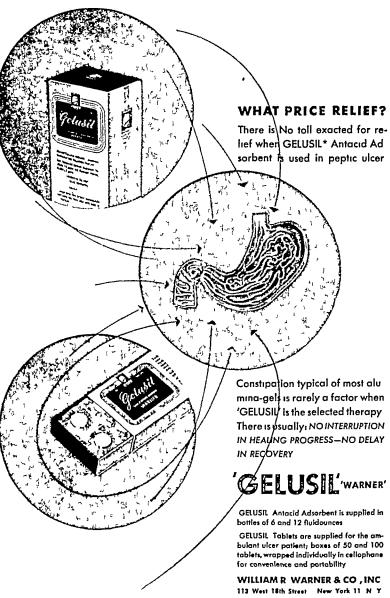
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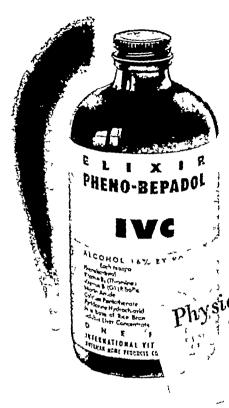
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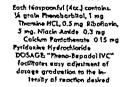
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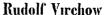
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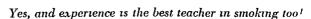


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# NEW YORK STATE JOURNAL OF MEDICINE

**VOLUME 47** 

SEPTEMBER 1, 1947

NUMBER 17

Published twice a month by the MEDICAL SOCIETY OF THE STATE OF NEW YORK Publication Office 20th and Northampton Sts, Easton, Pa Editorial and Circulation Office 292 Madison Ave, New York 17, N Y Change of Address Notice Should State Whether or Not Change Is Permanent and Should Include the Old Address Twenty-five cents per copy—\$2.00 per year Entered as second-class matter March 13, 1939, at the Post Office at Easton, Pa, under the Act of August 24, 1912

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	Monday, November 3, 194	7, Thr	ough Saturday, November	8, 1947	
Objective	To provide a more comprehensive standing of the many manifests allergy so commonly encount both the general practitioner scalist and to emphasize met diagnosis and treatment of diseases so that the physician pared to give the greatest and	ations of ered by and spe- hods of allergic as pre-	gether with his Treatment and is patient with	management of the o special lectures and e various allergie di	allergic 1 sym

Basic concept of chemistry immunology physiology, pathology botany pharma cology and psychodynamics as applied to the allergic patient Laboratory procedures such as the prepa

patient

Faculty

4 pproach

CASE REPORT

ration and standardization of extracts for testing and treatment skin tests serology and other miscellaneous pro-

Forty-four specialists in allergy and re-lated fields from prominent medical centers and colleges (For details see ANNALS OF ALLERGY pages 249-252 May-June 1947)

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Teaching Methods Lectures accompanied by lantern slides movies and other visual aids. Demon strations of technical procedures and allergic patients. Discussions in which all can participate

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Communications

CASE HISIC

DATE: 7/3/47

NAME: Doris Doe
ADDRESS: 147 Sunset Drive
DIAGNOSIS: Pruritus vulvae - Severe
TREATMENT Ultracain Vintment applied
REMARKS:
immediate relief of itching
... no irritation ... no recurrence

ULTRACAIN

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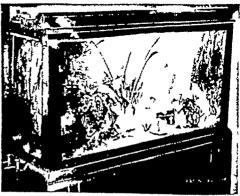
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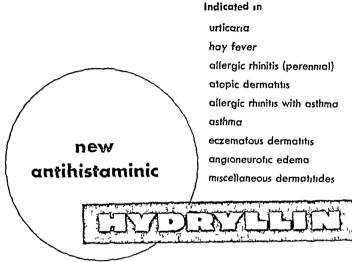
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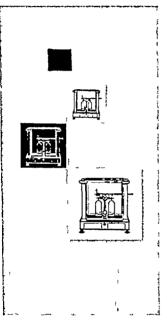
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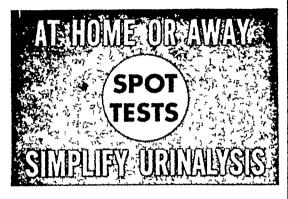
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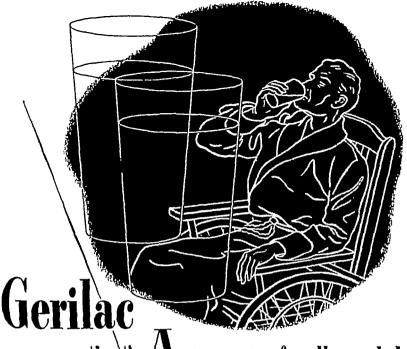
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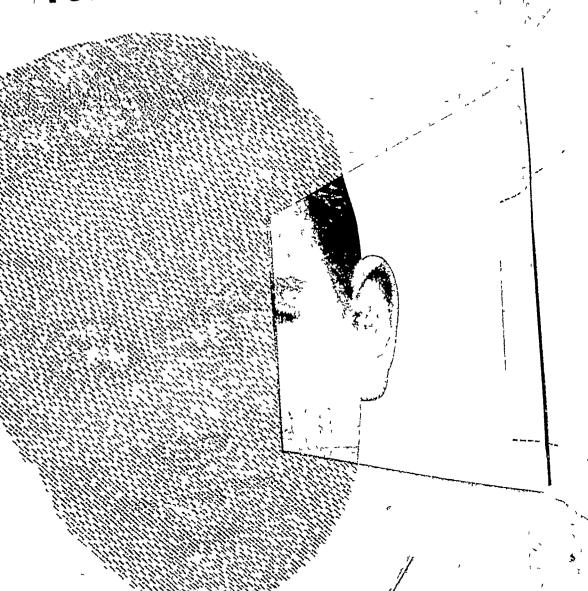
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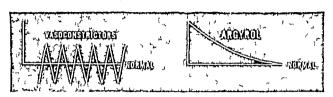
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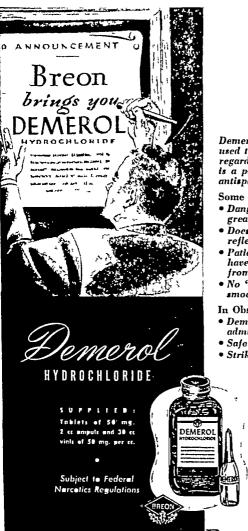
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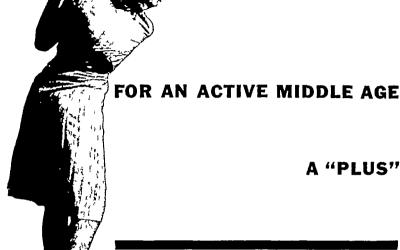
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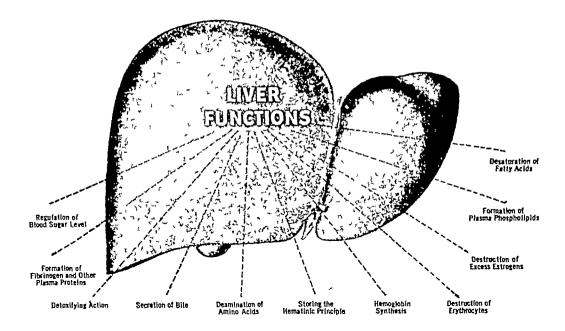
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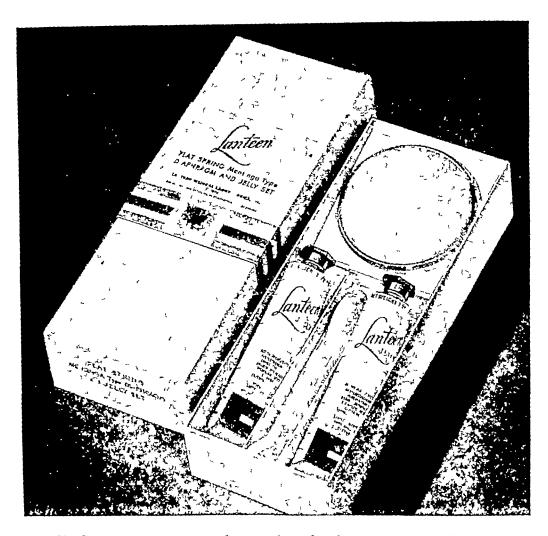
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> MEARINS, J.C. Practice of Medicine, St. Louis, C.V. Musby, 1940, p. 725

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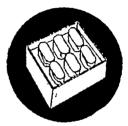
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**VOLUME 47** 

SEPTEMBER 1 1947

NUMBER 17

# Editorials

# What Your Taxes Buy in Washington I Federal Health Workshops<sup>1</sup>

Physicians in New York State to whom we address these greetings will be provoked, and we hope angered, but will not be surprised to learn about "Federal Health Workshops"

Our authority is House Report No 786, 80th Congress, First Session, submitted to the Committee of the Whole House on the State of the Union July 2, 1947 This is the Third Intermediate Report of the Subcommittee of the Committee on Expenditures in the Executive Departments Authorized to Investigate Publicity and Propaganda of Federal Officials in Formation and Operation of Health Workshops.

First, what are "Federal Health Workshops?" They are, in effect, Federal propaganda agencies, if we read pages 2 and 3 of the report correctly There have been two of them St Paul, Minnesota, February 6 to 10, 1946, Jamestown, North Dakota, September 27 to 30, 1946 The first was attended by "80 persons, 15 of whom were

Government employees, representing 7 different agencies in the Federal establishment." The second was attended by "98 persons , 18 of whom were Federal employees, representing 7 Federal agencies. The chairman of this meeting was Mayhew Derryberry, Ph.D., of the United States Public Health Service Apart from Federal personnel, there were no doctors of medicine in attendance at this meeting as delegates. The testimony before your committee indicated that no registered doctor of medicine was invited to participate"

This could have been oversight and not a deliberately planned discourtesy to the tax-paying, registered doctors of medicine Three "meetings in furtherance of these health workshops" had been previously held, the first in Washington, D.C., November 2, 1945, the second in Chicago, November 26 to 27, 1945 the third in Washington, D.C., December 10, 1945. The purpose of these three planning meetings was to create a Federal propaganda and publicity device,

I This is the first of a series of editori is on this subject.

the "health workshop," which in the words of the investigating committee was calculated to build up an artificial, federally stimulated public demand upon Congress for enactment of legislation for compulsory health insurance referred to by witnesses and publications as the Wagner-Murray-Dingell bill"

All the evidence before your committee indicates that these health workshops were planned, conducted, and largely financed with Federal funds, by a key group on the Government pay roll, who used the workshop method of discussion subtly to generate public sentiment in behalf of what certain witnesses and authors of propaganda refer to as socialized medicine It is evident from the record that most of the planning was done by the Federal officials in Washington prior to each workshop conference and that each meeting was devoted to their own purposes—that of organizing pressure groups to agitate for compulsory health insurance, as then pending in Congress

In preparation for the Jamestown Health Workshop, the Public Health Service distributed in advance to all invited delegates a packet of pamphlets published by the CIO, AF of L. the Physicians' Forum (a propaganda agency for the Wagner-Murray-Dingell bill), and the Government bureaus, in support of what certain witnesses and authors of propaganda refer to as socialized medicine These packets were mailed to the delegates in advance of the conference, at Federal expense They urged that letters be written to Senators and Representatives, advocating immediate action on the Wagner-Murray-Dingell bill

After the propaganda packets had been delivered, well in advance to the invited delegates, The Jamestown Health Workshop assembled on September 27

Details of the meeting of September 27 need not be given here. The purpose of the "training program" was to indoctrinate "a hand-picked group of leaders from the various local societies" in workshop procedure. This training program was handled entirely by the employees of the Federal Govern-

ment The investigating committee says, basing its reasons on the account of the meeting

Testimony demonstrating the efficacy of this indoctrination of delegates by the Federal officials was found in the formal summary of the Jamestown Workshop, as presented by the United States Public Health Service

One section of the "action program," approved by the conference, urged that congressional candidates and incumbents be polled by the committee, on their stand on the national health program, and that their opinions be sent to the State organizations for publication

In the opinion of your committee, this recital presents the complete picture of Government propaganda in action. The Federal employees arrange the meeting, invite the delegates, train the delegates, preside at the meetings, and then frame the formal summary of resolutions and actions.

And all of this is paid for with public moneys never authorized or approved by Congress for these or any like purposes

Enough of the report has been here quoted to convey to our readers the odor of improper activities of Federal agencies in propagandizing compulsory health insurance in 1946, under the subterfuge of "health workshops" The agencies "known to have participated in this campaign are The United States Public Health Service, The Children's Bureau, The Office of Education, The United States Employment Service, The Department of Agriculture, Bureau of Research and Statistics in the Social Security Board"

The registered doctors of medicine in the State of New York will not overwhelmingly approve of the diversion of their tax dollars as well as those of their patients to the underhanded, sly, not to say illegal, purpose of creating, sustaining, and propagating support for compulsory health insurance or "what certain witnesses and authors of propaganda refer to as socialized medicine"

# The Successful Approach

We are very fond of the medical profession and we want to see it get ahead — It may be useful from time to time to point out some of the reasons why it doesn't

A doctor has been defined as "a man who

finds out what you like to do and then tells you not to do it"

The converse of the proposition is equally true

In no field that we can think of has the

profession been more conspicuously unsuc cessful than in the treatment of poor posture in patients of all ages—the dumpy child, the awkward adolescent, the self indulgent adult of either sex who for one reason or another is unsightly, slightly obese, and difficult to be with

Why?

Because in dealing with such cases the doctor doesn't know How, and he doesn't know Why

"Physician, heal thyself'

If you want your child to stand up straight, set him an example Don't tell him to throw his shoulders back. Pull your own tail down, suck up your guts, and let your head go up where it belongs.

If you have a dumpy child, enquire into the problem of his endocrines and don't mention glandular disturbances in front of him

If you have a gangling adolescent make very sure there is no physical basis for the awkwardness. Weak feet, osteochondritis deformans juvenilis, or what have you

In the case of adults verging on obesity, be sure that their background was not—or is not—one in which "they never knew where their next bite was coming from" Obesity and alchohol are very closely related as compensations for insecurity

But after you have done all these things you will notice that everything involves either taking away from your patient something he likes, or trying to force him into doing something that he doesn't like

Now read the following blurb and mark how the same problems may be resolved commercially by a difference in the method of approach.

The patient who attempts to achieve weight reduction solely under a prescribed regime is often thereby conditioned to regard her obesity as a disease and the required routine of treatment as something unpleasant which has been forced upon her. She has a sense of abnormality and of

trying to do something alone. On the other hand, the patient who enrolls in the DuBarry Success Course is given the feeling that she is one of a group of thousands of women who have successfully reduced their weight and increased their personal attractiveness by doing exactly what she is doing The routine of treatment thus becomes a game at which she works hard because the ultimate goal is presented to her, not from a purely medical point of view, but from the more glamorous and appealing one of personal The obese woman usually has a feeling of inferiority because of her appearance against the background of her own group she feels isolated and develops a depression often bordering upon a psycho-neurosis and the attitude that improvement is hopeless coupled with her original weakness of will power causes her to fail to adhere to treatment she can be made to realize that she is one of many women who are overweight and who are successfully improving their appearance she thereby acquires the necessary incentive for cooperation

Smart advertising writing? Certainly A masterpiece This method gets results and the other sometimes doesn t And what, pray, are we physicians interested in? The welfare of our patients.

We present these ideas to the voung, intel ligent, enthusiastic, physically fit, idealistic, and inexperienced members of our Woman's Auxiliary

Shane Leslie once said that "the idea of the Church of England was to provide a resident gentleman for every parish in Iroland, and there have been worse ideas"

We suggest the possibility of a charm school for every town in the State of New York A school run by doctors of medicine who know why, by teachers who know how, and attended by pupils who want what they are going to get.

### Current Editorial Comment

The New Commissioner of Health Dr Herman E Hilleboe, formerly assistant surgeon general and associate chief of the Bureau of State Services of the United States Public Health Service, has been appointed commissioner of the New York State Department of Health by Governor Thomas E. Dewey <sup>1</sup>

<sup>&</sup>lt;sup>1</sup> A New and Psychological Approach to Weight Adjustment and Improvement of the Feminine Face and Figure. The Dubarry Success Course, page 16 Distribut n of this publication is stated to be excludively to the medical profession.

<sup>1</sup> Health News, Vol 24 Np. 27 July 7 1947

Dr Hilleboe's appointment became effective July 1, 1947 Shortly after he assumes his new office he will leave for a three-week tour of Europe where he will study health and tuber-culosis problems and attend three international health meetings

Dr Hilleboe was born in West Hope, North Dakota, January 8, 1906, and received his elementary school and high school training in He received the degrees, Bachelor Minnesota of Science and Bachelor of Medicine, at the University of Minnesota in 1929 He received the degree of Doctor of Medicine from the University of Minnesota Medical School in He had graduate training in pediatrics at the University of Minnesota Hospitals at He had graduate training in Minneapolis public health at the Johns Hopkins School of Hygiene and Public Health and received the degree of Master of Public Health from that school in 1935

After graduation from medical school, Dr Hilleboe engaged in rural general practice in Swanville, Minnesota Since 1935 he has spent full time in public health work specializing in tuberculosis control. In June, 1939, he was appointed as a senior assistant surgeon in the regular corps of the Public Health Service Early in 1939, he made special studies for the Public Health Service in tuberculosis control in the Scandinavian countries, England, Germany and France

Dr Hilleboe served with the Minnesota Division of Social Welfare in St. Paul, Minnesota, as chief of the Medical Unit from 1939 to 1942, on loan from the Public Health Service. Since 1942 he has been in charge of tuberculosis control activities in the Public Health Service in Washington, D.C. On July 1, 1944, he was appointed chief of the Tuberculosis Control Division of the Public Health Service with the rank of medical director. On November 1, 1946, he was appointed associate chief of the Bureau of State Services of the United States Public Health Service with the rank of assistant surgeon general.

Dr Hilleboe is a member of the Board of Directors of the National Tuberculosis Association, member of the Council of the American Trudeau Society, and member of the Board of Regents of the American College of Chest Physicians. He also is professorial lecturer in Tuberculosis at the George Washington University Medical School, Washington, D.C., and adjunct professor of medicine, Georgetown University

Dr Hilleboe was appointed by the National Tuberculosis Association on March 10, 1947, as a representative on the Council of the International Union Against Tuberculosis On May 31, 1947, he was appointed as the American member of the Expert Committee on Tuberculosis of the World Health Organization, Interim Commission

Dr Hilleboe surely comes with a wealth of experience to his present appointment. The Journal extends to him on behalf of the Medical Society of the State of New York a hearty welcome

School-Age Population Increases The educational system of the country, recently subjected to critical examination by reason of the teachers' strikes, seems to be due for a tidal wave of new business Says the Statistical Bulletin 1

As a result of the war and the postwar boom in births, our country will have a record number of children at the school ages in the 1950's In fact, more than 5,000,000 children will probably be added to the elementary school population of our country within the next decade

The number of children in the United States eligible to begin their formal education—the 6-year-olds—has been increasing slowly in recent years and now totals nearly 2,500,000 Their numbers will grow to almost 2,900,000 two years hence—In 1950 and in 1951, however, the new contingents of 6-year-olds will fall off somewhat—reflecting the decline in the birth rate in 1944 and 1945—but they will then resume their increase until they number nearly 3,300,000 in 1953—The latter figure is 40 per cent higher than that for 1945

The situation urgently calls for planning along practical lines in order that sufficient provision be made for the education of these This should include provision for child health guidance and, we hope, the rudiments, at least, of a program of health teaching in the public school system Such a program syllabus was, in recent years, the subject of much work and collaboration between the State Department of Education, the State Department of Health and the Council Committee on Public Health and Education of the Medical Society of the State of New York Apparently nothing has happened recently to advance this program Is the new flood of children to be as neglected in this respect as were their predecessors? Albany papers please copy

Published by the Metropolitan Life Insurance Company June 1947 p 3

# Scientific Articles

# THE INFLUENCE OF STILBAMIDINE UPON KIDNEY FUNCTION, LIVER FUNCTION, AND PERIPHERAL BLOOD IN MULTIPLE MYELOMA

Neurologic Sequelae of Stilbamidine Therapy

H ARAI, MD, and I SNAPPER MD, New York City

(From the Second Medical Service of the Mount Sinai Hospital)

IN PREVIOUS papers by Snapper, and by Snapper and Schneld' clinical observations and bone-marrow studies of multiple myeloma patients treated with still bamidine were presented. It was pointed out that stilbamidine abolished the pains of many patients with multiple myeloma and temporarily arrested but did not cure the disease relapses were frequent and the fatality rate remained high It was reported also that stilbamidine caused morphologic changes in the myeloma cells, consisting of the appearance of basophilic cytoplasmic granules which contain ribose nucleic acid and stilbamidine ent paper deals with the influence of stilbamidine upon kidney function, liver function and peripheral blood Special attention is given to the peculiar neurologic phenomena which develop after consation of treatment.

### Influence upon Kidney and Liver Function

It has been conclusively demonstrated in experimental animals that stillbamidine and other aromatic diamidines can produce renal and hepatic damage Devine\* in 1940 found that injec tion of sublethal doses of undecane diamidine and stilbamidine in rabbits gave rise to blood changes indicative of renal damage These changes developed prior to and independently of hepatic Daubney and Hudson<sup>2</sup> in 1941 reported delayed poisoning in cattle infected with trypanosomiasis and treated with large doses of pentamidine Extensive fatty degeneration of the liver was found and hypoglycemia appeared almost simultaneously with the onset of hepatic injury Hawking and Smiles' in 1941 observed that stilbamidine injected into mice infected with trypanosomes was absorbed not only by the trypanosomes but also was deposited in the liver kidneys and skin, and excreted in the urme

Wien, Freeman, and Scotcher\* in 1943 reported that in laboratory animals small or therapoutic doses caused no change in the blood sugar level Only when toxic or lethal doses were given were appreciable glycemic responses obtained consisting of initial hyperglycemia followed by terminal hypoglycemia. The glycemic responses were due chiefly to direct toxic action upon the parenchy matous cells of the liver and this led to depletion of glycogen reserves Doses which had no effect upon the blood sugar level produced an increase in blood urea nitrogen and nonprotein nitrogen thus substantiating the aforementioned work of Devine who showed that the renal damage occurs before and independently of hepatic damage The finding of extensive fatty degeneration of the liver after lethal doses of stilbamidine confirmed the conclusion of Daubney and Hudson that the most significant pathologic change produced by diamidines is found in the liver Kirk and Henry stated that in experimental animals, poisoned by a single lethal dose or by repeated toxic doses of stilbamidine the pathologic changes in the kidney are more constant and characteristic than those in the liver. The lesions consist of severe con gestion with focal areas of hemorrhage in the medulla and in the intermediate sone associated with tubular degeneration varying from simple cloudy swelling to necrosis and desquamation The same authors observed focal and diffuse fatty degeneration of the liver. In no instance did they find acute vellow atrophy or comparable

Delayed tone effects on the liver kidney, and nervous system of human patients with kala-axar were found only in cases treated with stilbamdine which had not been freshly dissolved Fulton and Yorke Barber Slack, and Wien Fulton, and Henry! reported that stilbamdine solutions exposed to light rapidly undergo chemical changes with resulting increase in toxicity not only to experimental animals, but also to humans. During the war, due to the closure of the Mediter

Presented before the 141st Annual Meeting of the Medical Society of the State of New York General Scenions, M y 9 1047

TABLE 1 —Influence of Stilbamidine Treatment on Kidney and Liver Function

												===
		Urine Albumin	Urine Bence-Jones	Blood Urea N trogen mg %	Blood Creatinine mg. %	Cholesterol mg %	Cholesterol Esters mg %	Phenolaulfonphthalein ın 2 Hrs	Cephalin Flocculation	Thymol Lurbidity	Alk Phosphatase King Armstrong Units	Icterus Index
1	Before Stilbamidine treatment After 5 175 mg Stilbamidine	‡	1	11 32*	1 6 2 7	140	90	40%	φ φ	ф	11 11	_
2	Before Stilbamidine treatment	1 4	++ + + + + + + + + + + + + + + + + + + +	18	1 2	140	]		φ	φ φ φ	14	
3	After 5 550 mg Stilbamidine Before Stilbamidine treatment	++++	φ	12 17	1 0 1 3	220	} ,	7007	<u>т</u> т	φ	9	1
ა	After 4 350 mg Stilbamidine	l I	II	12	1 7†	215	i	70% 75%	144	4	6	Ì
4	Before Stilbamidine treatment	ø	φ	14	13	220	145	, ,	++	1+++	8	i
5	After 6 750 mg Stilbamidine Before Stilbamidine treatment	ф	φ φ	12 12	1 2	165	83		+	+++	14	
J	After 2 100 mg Stilbamidine	φ	φ l	14		1			,			
6	Before Stillbamidine treatment	Traces	φ	12	1 4	ĺ			++	ф	10	
7	After 4 500 mg Stilbamidine Before Stilbamidine treatment	Traces ø	φ φ	14 14	2 1††	290			+++	φ	6	
•	After 4 050 mg Stilbamidine	φ Ψ		16	2 05	216	i		φ	φ	10	
8	Before Stilbanudine treatment	++	φ +	10	•		]		φ +	φ	7	
Ω	After 3 600 mg Stilbamidine Before Stilbamidine treatment	<del>+</del> +	φ	17 11		200	130		φ φ	φ	7 11	3
U	After 2,550 mg Stilbamidine	+	φ	18		200	200		φ	φ φ	ii	3
10	Before Stilbamidine treatment	Traces	φ	14		220	150	100%	φ +	φ		3 2 3
11	After 2 925 mg Stilbamidine Before Stilbamidine treatment	Traces +++	φ φ	8 15		260	140	100%	+	φ	8 13	3
11	After 2 250 mg Stilbamidine	TTT	φ	17				100%	φ	φ		
12	Before Stilbamidine treatment	+ ` `		18				60% 100% 45% 70%	ø	Ψ	9 7 7	
13	After 3 450 mg Stilbamidine Before Stilbamidine treatment	+	‡‡	15	1 2			70%	+	+	7	
13	After 5 700 mg Stilbamidine	φ	d l	18 11	0 9 1 5			60% 75%	ф	φ	1	
14	Before Stilbamidine treatment	φ	+++	13	טי			70%	ø ø	ф ф	(	2
	After 2 850 mg Stilbamidine	φ_	+++	íŏ_				70% 75%	φ	φ		3

\* Died ten days later from thrombopenia † Fifty three days later 1 0 mg % † Thirty-two days later 1 4 mg % creatinine and 37 mg % nonprotein nitrogen § Fifty six days later 1 4 mg %

ranean Sea, stilbamidine was flown from England in prepared bottled solutions These solutions became toxic during transportation, this may well explain the cases of stilbamidine poisoning which were published from Africa during the war Kirk and Henry<sup>6</sup> in 1944 confirmed the increased toxicity of old solutions Cumulative action played little or no part in the delayed toxic effects These authors collected autopsy findings in ten human cases of kala-azar treated with old bottled solutions of stilbamidine Their conclu-"No very satisfactory conclusion on sions were this point (delayed toxic effects) can be reached from the pathologic findings in this series Varying degrees of renal and hepatic injury have been found, but the pathology was, in most cases, greatly influenced by the disease, and there are unfortunately big gaps in the material which was available for examination It would be exceedingly difficult to define with certainty the parts played in the causation of the lesions by the drug, or the disease, or extraneous factors such as diet. or intercurrent infections, including infective hepatitis which was prevalent in the Sudan at the time"

No record exists of delayed poisoning following the use of freshly prepared stilbamidine solutions Kirk and Sati11 treated a series of 43 cases of

kala-azar with three different aromatic diamidines, including freshly prepared stilbamidine solutions, and found no instance of delayed toxic effects after intervals as long as two and onehalf to three years Sen Gupta<sup>12</sup> treated a large series of cases of kala-azar with freshly prepared solutions of stilbamidine and found no instance of delayed toxic effect upon the kidney or liver

### Personal Observations

We studied kidney and liver function in 26 myeloma patients during and after stilbamidine We are presenting the results on 16 patients treated until January, 1947 shows the data obtained in 14 of these patients The data obtained in 2 other patients who showed signs of renal failure after the termination of stilbamidine treatment are displayed in Table 2 patients 150 mg of freshly prepared stilbamidine solution was given either intravenously or intramuscularly, either daily or every second day total dose varied from 1.950 mg to 6,475 mg effect of the drug on renal function was studied by the determination of blood urea nitrogen, nonprotein nitrogen, and creatinine in the serum, and by the urine concentration test and the phenolsulfonphthalein excretion test The effect on the liver was studied by the cephalin flocculation test, thymol turbidity test, icterus index, bilirubin, serum cholesterol, and serum cholesterol esters, and in some cases

TABLE 2 -- Unpayorable Influence of Stilbanidine Injections in Two Patients with Mielona Kidneys

	Bulbami dine Given in mg	Urine Bence- Jones	Blood Ures Nitrogen	Non- protein Nitrogen	Blood Creatinine	Urle Acid	Phenol sulfon- pthalein	Cephalin Floceu- lation	Thymol Turbidity
1 January 23 1946 February 6, 1946 February 19, 1946 March 13 1946 March 15, 1946	300 1,950 12,00 (Treat ment	‡‡‡ ‡‡‡	16 16 28 44	38 2 75 0	3 0	5 2 3 5 3 0	25%	Negative	
March 18, 1946 March 21 1946 March 25 1946 April 3 1946 April 6 1946	stopped)	###	20 24 28 70	00 0 50 0	4 0 3 I 3 1	6 4 8 <sup>1</sup> 9 1	25%		

Died suddenly on April 11 1946. Autopsy mysioms kidneys.

Calcium serum between	13 and 16	mg per c	ent Calclu	m urine on	Bauer-Aub	diet 355	to 309 nu	daily	
2. October 1946 December 28, 1946 January 3 1947 January 11 1947	* * 7δ 1 075	###	19 20		8 03		20% 25%	1+	
January 15 1947 January 22 1947	1 675 2 100 (Treat- ment	Ĭ Į Į	11 50		303	6 06	20%		ļ
January 24 1047 January 76 1917 January 27 1947	stopped)	###	50 24 41		4 8 3 8				
January 30 1917		+++	44	60	4 9		ľ	1+	Negativo

Died in uremia on March 4 1047 Autopsy myeloma kidneys

by hippuric acid excretion and glucuronic acid excretion (Snapper Greenspon and Saltzman) 13 14

In 14 cases there were no significant changes suggestive of impairment in ronal and bepatic function
during or after treatment. Case 13 serves to illustrate that massive doses of freshly prepared stillamidline can be given with impunity. This patient
received periodic courses of stillbamidine for twenty
two months without demonstrable effect on the
kidney or liver.

As for the possible influence of stilbamidine upon renal function, it may be important to note that in Cases 3 6 and 7 the scrum creatinine had increased slightly at the time the stilbamidine treatment was terminated In all three cases the creatinine values subsequently returned to normal. Among the 14 patients collected in Table I there were three deaths (Cases 1 2 and 6) during and after stilbamidine therapy In all three nitrogen retention was present before death which however, could be explained by the underlying disease. At autopsy none of the three cases revealed evidence of stillbamidine intoxi-Case I had impaired renal function with moderate exerction of Bence-Jones protein in the urine before the institution of therapy histopathologic study of the kidneys revealed mycloma kidneys, a frequent cause of renal insufficiency Case 2 on admission to the hospital had a cord bladder due to injury of the spinal cord following collapse of the vertebrae destroyed by myeloma throughout the treatment and up to the time of death it was necessary to maintain continuous tidal drainage. This patient developed urea retention shortly before death, six months after the stilbamidine treatment had been terminated. Study of the kidneys of this case revealed chronic pyelonephritis and nephroscierosis a common finding in such patients. Case 6 was a diabetic patient whose diabetes mellitus was well controlled throughout the treatment. During the stilbanddne treatment no change in renal function was observed. A follow up examination thirty two days after termination of the treatment also showed normal values for the nonprotein nitrogen and creatinine of the blood. Seven weeks after the last injection of stilbandine the patient was read mitted with severe diabetic ketosis and nitrogen retention, and expired in a few days. The kidneys showed advanced arterial and arteriolar sclerosis. Thus none of these 3 cases showed renal changes comparable with the lesions observed in animals poisoned with stilbandine.

This even held true in the two following patients in whom stilbamidine acted unfavorably on renal function (Table 2) The first patient, who suffered from extensive multiple myeloma, had been found in another hospital to show considerable Bence-Jones proteinuria and also hypercalcemia. At that time the nonprotein nitrogen had been found to be 35 mg per cent that is within the upper limits of normal After the patient's admission to the Mount Sinai Hospital the presence of Bence-Jones proteinuria was confirmed. The urea nitrogen of the blood was found to be 16 mg per cent, the uric acid 5 2 mg per cent. During the time of observation the hypercalcomia varied between 12 and 16 mg per cent. On a Bauer Aub diet a significantly increased calcium excretion was found, varying between 355 and 399 mg perday

Stilbamidine injections were given every other day between February 12 and March 14 1946 totaling 21 Gm. On the day after the last injection (March 15 1946) the patient was nauscated The blood urea nitrogen had then increased to 44 mg per cent, the nonprotein nitrogen to 75 mg per cent. Intravenous infusions of glucose were given. The urea nitrogen gradually decreased and reached 20 mg per cent on April 6. The patient died suddenly on April 11, 1946. At autopsy only myeloma kidneys were found. In this case the combination of Bence-Jones proteinuria and hypercalcemia must have led to deterioration of the renal function. Renal failure was evidently precipitated by the stilbamidine.

The second patient was a man, 74 years old, who was admitted to another hospital in October, 1946 Here Bence-Jones proteinuria was found, and the diagnosis of multiple myeloma was confirmed by sternal marrow puncture. At that time the urea

nitrogen was found to be 19 mg per cent

At admission to the Mount Sinai Hospital the blood urea nitrogen was already increased to 26 mg per cent before stilbamidine treatment was started on December 31, 1946 On January 3, 1947, the phenolsulfonphthalem excretion appeared to be unsatisfactory (20 per cent) This test was repeated eight days later and an excretion of 25 per cent was On January 10, the blood creatinine was 3 02 mg per cent However, when on January 16 the blood urea mitrogen was reported as 11 mg per cent, there seemed to be no special reason for con-The patient received thirteen injections of stilbamidine, totaling 2 1 Gm. By January 22, the day after the treatment was terminated, the blood urea nitrogen had risen to 50 mg per cent, the creatimine to 48 mg per cent Intravenous infusions of glucose were given but when the patient left the hospital on January 31 the urea nitrogen was still 44 mg per cent, the nonprotein nitrogen 60 mg per cent, and the creatinine 49 mg per cent turned on March 1, 1947, in a desperate condition The blood urea mitrogen was then 130 mg per cent. the creatanine 72 mg per cent, and he died a few days later

At autopsy typical myeloma kidneys were found In this patient the combination of myeloma kidneys and advanced age may well have been the mun factors in the deterioration of renal function during the stilbamidine treatment

In the ten patients treated since January, 1947, and not mentioned in Tables 1 and 2 no untoward reactions were noted

Liver function tests performed during and after stilbamidine treatment yielded normal values Apart from the tests mentioned in Tables 1 and 2, hippuric acid tests were performed in Cases 7, 9, 11, 12, and 13 after the stilbamidine treatment had been completed. The results were normal. In none of the 5 patients who came to autopsy were signs of liver degeneration found, the same was true of the 2 patients who developed signs of uremia during the treatment.

# Influence Upon the Peripheral Blood Picture

Wien, Freeman, and Scotcher<sup>5</sup> studied the effect of the diamidines, stilbamidine and propamidine, on the peripheral blood picture of guinea pigs. They gave repeated injections of toxic

doses and found no significant changes Our review of the literature reveals no report of hematologic complications during the treatment of human kala-azar with aromatic diamidines. In multiple myeloma treated with stilbamidine, this problem is of considerable importance because most myeloma patients show signs of myel ophthisic anemia often accompanied by thrombocytopenia. Our studies are presented in Table 3

Several noteworthy changes were observed Case 15 developed marked eosinophilia during two subsequent treatments. It is probable that this was due to stilbamidine since the eosinophila reappeared when the treatment was repeated In other patients no marked eosinophilia occurred during the treatment Both eosinophilia and lymphocytosis are known to occur in multiple myeloma, 15 eosinophilia existed in Cases 5 and 6 before the institution of therapy Case 3 had a platelet count of 150,000 before treatment After treatment it fell to 70,000 and eventually rose to 160,000 In all the other cases the platelet count was not influenced Even in cases with thrombopenia,16 the number of platelets did not drop progressively during or after treatment. It is important to note the absence of leukopenia during stilbamidine treatment The leukopenia observed in Case 15 during the later phase of treatment developed only after periodic courses of radiotherapy had been started. There were no significant changes in the hemoglobin and red cell levels other than what may be expected in the natural course of this disease The patients treated with stilbamidine, like all myeloma patients, needed occasional blood transfusions

Thus it appears that still amidine even in the large doses given in this series has no effect upon the hemopoletic system

# The Effect on the Nervous System

Napier and Sen Gupta<sup>17</sup> in 1942 reported 7 cases with subjective disturbances and dissociated anesthesia over the areas supplied by the sensory branches of the trigeminal nerve, developing a few months after cessation of stilbamidine therapy. They described this condition as diamidine-stilbene neuropathy. This delayed toxic effect of freshly prepared stilbamidine has been confirmed by Sen Gupta<sup>12</sup> in 1943 and by Kirk and Henry<sup>6</sup> in 1944.

Diamidino-stilbene neuropathy is reported to occur between two and a half and five months after cessation of therapy. It is characterized by numbness, formication, heaviness, and itching There is dissociated anesthesia over the areas supplied by the sensory branches of the trigeminal nerve the sensation of light touch is lost but the sensations of pain, temperature, and pressure are intact. These peculiar features distinguish this

TABLE 5 --- INTLUENCE OF STILBANIDING TREATMENT ON THE BLOOD PICTURE OF MYELOMA PATIENTS

	***************************************	TECHNOLOGY OF DITE				142 0200	71010					
		Stilbamidine	Hemoglobin	Red Blood Count	White Blood Count	Platelets	Polymorphonuclears	Lymphocyte	Monocyt	Eosinophils	Plantas cells	Staff cells
1	April 23 1946	8	88	2 80	4,500	20 000	41	50	3 3	1	2	4 3.
2	June 25 1946 April 7, 1946	5 1″5	80 62	2 80 2 30 3 71	3 400 7 000	24 000	18 66	43 23	3 5	1	4	3*
2	June 25 1946	8.550	45	3 30	7,200		69	25	3	1 3 1	5	4
_	September 16 1946	65 days after	70	3 85	5 100	1 1	09	^0	į į	1 1	1	i 🛊
3.	June 19 1946 August 8 1946	4.350	45 58	2 47	8 *00 0.500	150 000 100 000	40	8 48	4	1	•	1 1
	October 7 1946	65 days alter	00	3 32	5 700	60 000	20	6.1	4	i i	¥	3 2 6
4	June 24 1946	\$	60 50	}	8 700	100 660	58 70	20	4		•	9
	October 10 1946 November 30 1946	6,780 51 days after	An .	ļ	4,500	100 000	66	96	6	*	Ť	7
5	July 2 1946	<b>→</b>	75		7,500	1 1	33	29	- 0	32	ø	Ý
	July 31 1946 January 1 1947	1,800 165 days after	60 74		7,500 8,550	[ [	40 58	40 37	8	11	*	6
6	May 26 1946	100 male mites	50	3 19	3,800	150 000	52	20	ó	16	*	3
	August 4 1946	4,500	65	1	4.300	1	60	18	4	18	¥	
7	September 18 1946	46 days after	70	3 89	3 900	i I	68	22	8	2	•	22
•	February 2 1946 March 12, 1946	1.030	56	2 98	6,700 6,600	1 1	58 70	30 21	5	3 1	;	i
	April 3, 1946	20 days after	60		5 100		55	27	7	4	ě	4
Б.	June 27 1916	1.050	55	3 3 2 74	6,000		70	- <del>1</del> 1	2 6	· •		6
	Reptember 4, 1946 November 23, 1946	101 days after	58 64	2 /4	4,000	! I	46 49	40	ő	1 1	1	6
9	Beptember 14 1946	ّ ہا	85	3 41	8,000	140 000	66	23 25	4	3	¥,	4
	November 1, 1946	3 600	50	1	7,800	' '	43	25	10	3	•	34†
10	November 27, 1946 January 19 1947	<b>1</b> .550	75 68		5 900 5,500	190 000	54 41	37 49	8	1 1	*	🛊
11	November 18 1948	•	78	1	6.000		70	17	á	2	- 1	7
12.	January 7 1947	2,925	72	] `	6,300	280 000 ]	61	81	4	<b>≠</b>	•	1 4
12.	March 26, 1946	2.250	66 73	3 69	5 700 3.500	1 1	78	30 14	6	2	\$	3
	July 24 1946	83 days after	73		7,500	1 1	72	20	4	3	ĕ	1 5
13.	February 6, 1915 March 23, 1945	\$.500	50		4,300	1 1	56 68	32	6	1 2	•	5 2
14	April 1 1946	J.500	53	4 80	3,200 6 100	1	60	33	1 1	l i l	- 1	1 6
	June 7, 1946	8,450	85 80		6,000	1 1	ėń.	_6	3	3 !	\$	Ĭ.
15	December 7, 1945 March 11 1945	176 days after	80	8 40	8,000		56 59	20	3	2 3	۰	3
	July 9 1048	2.550	63 74	0 10	10,200 7 100	!	52	35 32	3	11	•	5
	October 4 1945	85 days after	75		8 200	l 1	43	80	0	8	- 4	1
	June 7 1945 July 5 1946	2.500	82 68	4 24	8 100		60	50 22 28 33	3 8	28	*	
	January 13 1947	1 2,500 1 5 700	78	}	5,500 3 900	1 . !	41 56	33	8	28	1	1 2
16	January 7, 1946		l co	1 93	8 900	80 000	47	44	3	i i	7	1 4
17	January 27 1946 January 26, 1946	2,500	40	2 65	5.900	80 000	58 50	33 35	1 1	4	*	5
	January 28, 1940	2 100	58	3 40	4.500		46	46	8	انتا	1	
18.	January 14 1947	1 4	58	3 21	4 000	150 000	67	20	8	ا بة ا	ě	10
-	February 5, 1947	₹,400	66	3 54	4,100	140 000	67	26	_3_	_1_	<u> </u>	

Also 19 per cent myslocytes, 5 per cent metamyslocytes 8 per cent mysloblasts.
 † Also 3 per cent metamyslocytes and 2 per cent myslocytes

neuropathy from the known neuropathies of the trigeminal neuropath, peripheral neuropath, and interstitial neuritis. Subjective and objective disturbances involving the trigeminal nerve do not occur in kala-axar un treated or treated with different antimony compounds.

It is now believed that diamidino-stilbene neuropathy is due to toxic degeneration of the principal sensory nucleus of the trigeminal nerve. The selective action of stilbamidine upon this site may well be due to the ethylene component of this drug. After experimental stilbamidine intoxication in dogs, thrombosis, perivascular hemorrhage and infiltration, neuronal degeneration and myelin disintegration have been observed.

Sen Gupta<sup>12</sup> observed 17 cases of diamidinostilbene neuropathy among 104 cases of kala-axar treated with freshly prepared stilbamidine. The incidence would have been higher if all the cases could have been followed for a sufficient length of Each of the 104 cases was treated with 1 mg. of stilbamidine per pound of body weight, and the number of injections varied from nine to fifteen. Immediate reactions after the injections (hypotension tingling in the face flushes) occurred as commonly among those not developing the neuropathy as in those who did. Hence, Sen Gunta concluded that dosage was not responsible for the delayed toxic effect and that immediate toxic reactions are no indications of susceptibility to subsequent neuropathy In most of the 17 cases the symptoms appeared between the third and fourth month after cossation of therapy The principal subjective symptoms were paresthesis and anosthesia limited to the forehead and face in all cases except one in whom they spread Five patients complained of itching inside the eyes and ears, 2 of twitching of the facial muscles, and in 3 patients there was blinking of the These signs were due perhaps to irritation of the neurones of the nucleus of the facial nerve which he close to the principal sensory nucleus of the trigeminal nerve In 3 cases there was analgesia of smaller areas within the larger areas of dissociated anesthesia, indicative of probable extension of the lesion, caudad over the spinal tract of the fifth nerve and its nucleus There were slight troplic changes of the skin in 4 cases, probably due to rubbing and There was a gradual subsidence of the paresthetic symptoms but no change in the objective dissociated anesthesia during observation extending as long as twenty-two months A variety of agents including vitamin B, were used in an effort to relieve the symptoms. Only cobra venom solution (1 100,-000) in gradually decreasing doses proved to be of some value Sen Gupta<sup>12</sup> states "The neuropathy is apparently not dangerous to life, it mercly causes rather unpleasant symptoms to some of the patients In most cases it does not show any sign of extension, and the tendency (of the neuropathy) is to a very slow recovery "

We were able to follow 18 patients for more than two months after the stilbamidine course was terminated Of these 18 cases, 10 developed diamidinostilbene neuropathy, as explained in Table 4

The onset of the symptoms varied from one to one and a half months in Case 7, and in Case 18, to five months in Case 4 after the cessation of therapy

In the majority of the cases the interval was two to three months The number of injections varied from fourteen in Case 6 to forty-five in Case 7, and the total dosage from 2,100 mg in Case 6 to 6,750 mg in Case 7 Most of the patients who did not develop the neuropathy were observed for only two to three months after the end of therapy However. I patient observed for twenty-five months never developed the dissociated anesthesia. In all the cases immediate toxic reactions were observed at one time or another during therapy, the reactions varied from slight flushing and tingling of the face in Case 7 to sudden fall in blood pressure, and nausea and vomiting in Cases 1 and 2 In all the cases, dissociated anesthesia over the areas supplied by the sensory branches of the trigeminal nerve was present. and in Cases 2 and 6 there was extension to the neck

The paresthetic symptoms were mild except in Case 2, whose symptoms were unusual, for which reason the case will be discussed in some detail This patient was a 44-year-old white woman with multiple myeloma who received 23 injections of stilbamidine or a total dose of 3,450 mg Three and a half months after the last injection, she awoke one night with sensations of numbness, tingling, and heaviness in and around the nose Gradually these symptoms spread to the forehead, which began to feel as "heavy as a stone" Gradually the cheeks and the neck became involved, finally even the conchae of the ears During the fourth month, after the last injection, intense itching of the external canthus of both eyes and corners of the mouth developed The symptoms over the forehead, face, and neck gradually became less intense, but the itching became more severe and led to uncontrollable rubbing of the eyes. Six months after the end of stilbamidine therapy, it became necessary to readmit this woman in order to treat the bilateral conjunctivities and blepharitis which had developed be cause of constant rubbing. After the use of a soothing ophthalmic ointment supplemented later by vitamin B<sub>1</sub> injections and by benadryl, the symptoms and inflammation gradually subsided

In all the cases there was gradual subsidence of the symptoms Dissociated anesthesia, however, often remained with neither extension nor regression. It it noteworthy that Case 1 of Table 4 also showed no further extension of the symptoms and signs despite resumption of stilbamidine injections after the development of the neuropathy. The same held true in Case 2.

# Discussion

Although there is experimental evidence that stilbamidine produces renal and hepatic damage, the literature gives no conclusive evidence of renal and hepatic damage in human cases of kala-azar treated with freshly prepared stilbamidine solutions. In our cases of multiple myeloma, freshly prepared stilbamidine solutions also were employed. In 5 patients who came to autopsy postmortem studies revealed no evidence of stilbamidine damage to the liver. In none of our patients did we observe biochemic changes suggestive of immediate or delayed toxic effect upon the liver although the dosage used in multiple myeloma was several times larger than the dosage used in kala-azar.

However, the influence of stilbamidine on the kidney function of myeloma patients must be watched carefully In all patients with Bence-Jones proteinuma, there is danger of uremia due to myeloma kidney The experiences reported here seem to indicate that stilbamidine may occasionally precipitate renal failure in patients with imminent uremia due to myeloma kidney such patients have been encountered among 26 patients treated In both patients Bence-Jones proteinuma evisted In the first patient hypercalcenna, in the second patient old age may well have been additional predisposing factors in these two patients the autopsy only revealed the presence of myeloma kidneys without the lesions which have been described in animals as sequelae of stilbamidine poisoning In 3 other patients with multiple myeloma who came to autopsy such renal lesions were absent

It is necessary to make a careful study of renal function before the treatment with stilbamidine is

<sup>\*</sup> The postmortem findings of these cases will be reported in detail in a future communication

TABLE 4 -TRIGHTHAL NEUROPATET AFTER STILBANIDING TREATMENT OF MULTIPLE MYELONA

	Stilbamidine	Omet of Symp- toms After		l'eriod of Observation After Treatment	
Cases	mg.	Treatment (in Months)	Symptoms and Signs	(in Months)	Progress
1	2,550	21/s to 3	Numbress atiffness, heavi- ness and itel ing of nose forehead and cheek Dissociated anesthesia over nose and cheek	25	Slight numbness and stiffness of n.so forehead and cheeks. blight dissociated anesthesi over hose
3	3,450	3 to 31/1	Numbees heaviness and tingling of niese, I re- bend cheeks and neck spannottle itel ing inside eyes. Dissociated anesthesia over these areas	10	ips modicatching of eyes and fore- head still present. Eyebrows partially rubbed off. Slight blepharconjunctivitis due t- rubbing. Attacks and severity of itching moderately decreased with the drug benadry! Dis- sociated anesthesis present over ndes, forehead and to slight extent over left cheek.
3	4,350	3	Eligit numbress of nose and forehead with alight dis- sociated anesthesia over these areas	8	No ymptoms. Dissociated ansa- thosia cannot be demonstrated
4	,250	8	Numbness and tingling sen- sations of nose forehead, and cheeks with dissort ated anesthesia over these areas	11	Numbres and taugling sensations less intense. Dissociated ansa- thesia unchanged
3	4 050	2	Tingling sensations over forehead and right check with dissociated anes thesis over these areas	8	Slight numbress stiffness and spaumodic teching of nose fore- bead and cheeks. Attacks and severity of itching issued with drug pyribensamine. Dissoci ated anesthesis over nose fore- bead, and cheeks.
O	2 100	3	Formeation and heaviness over nose forehead, cheeks and neck. Dis- sociated anesthesis over nose forehead cheeks and right sid of neck.	8	Slight formication and tingling over nose, forehead and cheeks. Spasmodic itching inside the eyes. Attacks and severity of itching lessened with benadry! Dissociated anesthesis over nose forehead, right cheek, and to lesser artent of left cheek
7	6,750	11/2	Elight numbness of noss and forehead with slight dis- sociated anesthesia over these areas	3	No symptoms. Equivocal dissoci- ated anesthesia over noss and forchead
8	,873	11/	Elight numbress and ting ling over nose and fore- head Dissociated ance- thesis over nose to lesser degree over forehead	3	Unchanged
	3 100	n	None	3	
10 11	7,550 2 050	o o	None None	2/	
12	5,575	0	None	1 2	
13	4 0.30	ň	None	1 .	
14	3,225 4,200	ŏ	None	2	
15	4,200	0 0 0	None	2 2 2 7	
16	5 025	2	Numbress and stiffness of nose foreband and checks. Dissociated anesthesis over nose and forebead	7	Slight numbness of nose, forehead and cheeks. Skin dry with alight scaling Dissociated anes- thesis over nose and forehead
17 18	2,500	0	None	25	
18	1st series, 1 *00 *nd series, 1,500	o o	None	21	Trabanesed 117 months after he
	series, 1,000	After termina	vumbnessandstiffnessmost marked over frehead.	,	Unchanged 11/ months after be- ginning of signs
		tion of 2nd	Also over nose cheeks	i	
	1	sories	Also over nose checks lips, and chin. Dissoci- ated anesthesis over fore- bead		

initiated The urea introgen, nonprotein nitrogen creatinine, and uric acid content of the blood must be determined. The phenolalionphthalein test and the concentration test must be performed. During the treatment weekly blood urea nitrogen determinations are necessary.

The danger to renal function should not be exaggerated. The two untoward results reported were the only ones among 20 patients with multiple mycloma, 17 of whom showed Bence-Jones proteinuma. Other patients not mentioned in thus review had elear-cut impagment of

renal function before the inception of stilbamidine treatment but did not develop uramia during the administration of the drug. It is true that in such cases stilbamidine was given at longer in tervals than usual often only twice per week.

After stilbamidne treatment of multiple myeloma there were no serious changes in the peripheral blood which could be ascribed to the drug One patient developed cosmophilia. It is evident thus that multiple myeloma patients with myelophthiac anemia and thrombocytopenia can be treated with no fear of aggravation by the drug

The neurologic sequelae peculiar to stilbamidine therapy occurred in 10 out of 18 patients who could be observed for more than two months after termination of the injections Gupta's series,12 the incidence was 17 out of 104 cases, although this author agrees that the incidence would have been higher if he could have fol-The higher incidence in our lowed more cases series well may be explained by the higher dosage Whereas in Sen Gupta's series the total dose given varied from 575 mg to 1,660 mg, in our series the range was from 2,100 mg to 6,750 mg was well illustrated by Case 18, who for four months had no neurologic signs after 1,200 mg of stilbamidine had been given but who developed the characteristic neuropathy one month after a second series of 1,500 mg of stilbamidine had been administered

The neuropathy observed in our cases of multiple myeloma was typical and was characterized by subjective symptoms which subsided gradually and spontaneously. The objective dissociated anesthesia tended to persist for a long time with no extension beyond the neck even when stilbamidine injections were resumed after the neuropathy had developed. The neuropathy did not endanger life.

# Summary

Repeated injections of stilbamidine dissolved immediately before use have no delayed toric effect on the liver or hemopoietic system of persons suffering from multiple myeloma. The development of renal insufficiency in some myeloma patients during or following stilbamidine therapy is due to exacerbation of a pre-existing renal insufficiency caused by myeloma kidneys or by other pathologic changes. Before stilbamidine injections are given, the renal function should be tested. Before treatment, and once per week during treatment, the blood should be analyzed for urea, nonprotein nitrogen, and creatimne

Stilbamidine can be given to patients who have signs of renal failure but in such cases not more than two or three injections per week should be administered

The peripheral blood changes which were occasionally observed could be expected to occur during the natural course of this disease. In one patient eosinophilia developed

With the large dose of stilbamidine given to myeloma patients there is a high incidence of neuropathy due to toxic degeneration of the principal sensory nucleus of the trigeminal nerve. In most of the patients the symptoms only cause discomfort, which tends to subside gradually. In 1 patient (Case 2 of Table 4) the discomfort was considerable. The neuropathy does not endanger life, and once it develops there is no progression even after resumption of stilbamidine injections.

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# NEW SEMINAR ON VENEREAL DISEASE CONTROL FOR PRACTICING PHYSICIANS

A new series of lectures for practicing physicians on the diagnosis, treatment, and management of venereal diseases will start at the New York City Department of Health, 125 Worth Street, Manhattan, on Saturday morning, September 13 Meetings will be held every Saturday morning at 10 30 AM through December 20 Experts in special fields of venereal disease control will participate in the seminar, lectures will be illustrated

No registration or fee for the course will be required Sessions are informal Physicians who attend may be reached by their offices at WOrth 2-6900, Extension 460

All meetings will be held in Room 330

The schedule of lectures follows September 13,

Practical Aspects of Immunity in Venereal Disease, September 20, Modern Treatment of Gonorrhea, September 27, Psychosomatic Aspects of Venereal Disease, October 4, Diagnosis and Treatment of Early Syphilis, October 11, Late and Latent Syphilis, October 18, Cardiovascular Syphilis, October 25, Neurosyphilis, November 1, The Minor Venereal Diseases, November 8, Syphilis of the Eyc, November 15, Differential Diagnosis of Early Syphilis, November 22, Office Treatment of Early Syphilis with Pencillin, November 29, Syphilis in Pregnancy, December 6, Serologic Tests for Syphilis, December 13, Reactions Occurring in the Therapy of Venereal Diseases, December 20, Nonvenereal Diseases of the Gemtalia.

### HEMOLYTIC DISORDERS\*

Recent Advances in Diagnosis, Prevention, and Treatment

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THE individual types of hemolytic anoma L are relatively rare, but collectively they con stitute a sixable group During the past decade much has been learned concerning the various mechanisms of rapid red cell destruction, and it. therefore, is appropriate that we review briefly recent developments pertaining to this clinically important and complex group of disorders. The purposes of this paper are to present some of the newer concepts of hemolytic mechanisms, to describe recently developed diagnostic procedures, and to comment on preventive and thera pentic methods.

### Classification

A working classification of hemolytic anemias is given in Table 1 It is helpful to divide this heterogeneous collection of diseases into two large groups. In the first group supposedly normal red cells are acted upon by abnormal extracellular forces, and in the second, the erythrocytes themselves are defective and therefore subject to rapid destruction Many of the extracorpuscular causes of hemolysis are well established even though the exact mechanism of their action is not understood Among these are chemical agents such as phenythydrazine and sulfanilamide, physical agents such as heat, when productive of severe thermal burns, and infectious agents such as malaria parasites

Of the antibodies which may be responsible for hemolytic phenomena, anti A, -B, and -Rh are best known More will be said later concerning these and the other types of antibodies Insted

The role of an overactive spleen in destroying not only red cells but also white cells and platelets has been stressed, particularly by Doan and his associates 1 Although the spleen is no longer considered an important graveyard for eryth rocytes under normal conditions, the phagocytic cells of the spleen may at times become

Presented at the 141st Annual Meeting of the Modical Society of the State of New York, Buffalo, General Sessions Symposium on Hematology May 9 104.

The observations described in this report were made ander a contract between the University of Rochester and the Office of Naval Research.

"The structure owhich hypersplenium" may be responsible for the symptomatic hemotytic assemise occasionally seen is association with other diseases, sepsellily malignately is uncurrian. This variety of hemotytic disorder has not been included in the elassification given in Table 1.

overactive and may be responsible at least in part for the development of anemia \*\*

If normal red cells are transfused to patients in whom there is an extracorpuscular cause for hemolysis, the donated cells may be destroyed as rapidly as the patient's own erythrocytes 1-1 If the patient's cells, on the other hand, are removed from their abnormal environment and transfused to a normal recipient they may have a normal life expectancy of from 100 to 120 days. In patients having intracorpuscular defects the results of transfusion are exactly the reverse That is, normal donated cells are handled in a perfectly normal manner, while the patient's own erythrocytes are quickly disposed of when given to a normal recipient. 3-6 Transfusion studies of this type have been carried out in a number of laboratories in recent years and have aided materially in localizing the abnormality in various types of hemolytic anemia Such studies are usually made by transfusing cells which differ from those of the recipient with respect to M-N type or by giving group O cells to recipients belonging to one of the other three major blood groups Following transfusion the donated cells can then be differen tiated from those of the recipient by use of an appropriate antiserum.7

The most important types of intracorpuscular defects are listed in Table 1 Spherocytes are regularly found in congenital hemolytic anemia,

TABLE 1.—CLASSIFICATION OF HENCLYTIC DISCRICES CLASSIFICATION OF HEMOLYTIC DISORDERS.

EXTRACORPUSCULAR CAUSES

CHEMICAL, PHYSICAL, INFECTIOUS AGENTS ANTIBODIES ANTI A. B. Rh.-Hr ISOAGGLUTININS COLD AGGLUTININS COLD. HEMOLYSINS WARM HEMOLYSINS "UNIVALENT" ANTIBODIES HYPERSPLENISM INTRACORPUSCULAR DEFECTS

CONGENITAL SPHEROCYTIC HEMOLYTIC ANEMIA SICKLE CELL ANEMIA THALASSEMIA (COOLEY S) PAROXYSMAL NOCTURNAL HEMOGLOSINURIA ATYPICAL HEMOLYTIC ANEMIA

but they are no longer considered pathognomonic of this disease because they have been observed in many of the so-called "acquired" cases due to extracorpuscular causes <sup>8</sup> Spherocytes, which are thick cells appearing densely stained in smears, are regarded by some as injured cells, and a wide variety of injurious agents, such as heat and antibodies, has indeed been shown to cause spherocytosis <sup>9</sup> It seems likely, however, that in congenital hemolytic anemia the red cells are inherently defective, whereas in acquired hemolytic anemias the cells are normal when released from the bone marrow but are rendered spherocytic by the action of such agents as heat, chemicals, or antibodies

Sickled cells may not be present in smears of the peripheral blood of patients with sickle rell anemia but they are easily produced in sealed wet preparations or in blood through which carbon dioxide has been bubbled vigorously Target or "Mexican hat" cells, which are thin and highly resistant to hemolysis in hypotonic salt solution, are regularly found in ordinary smears of blood from patients with sickle cell anemia and are seen also in smears prepared from patients with thalassemia It should be emphasized that thalassemia or Mediterranean anemia ocurs in both the severe form known as Cooley's anemia, or thalassemia major, and in the mild form known as thalassemia minor 10 The incidence of the latter among the Italian population of Rochester has been estimated at 4 per cent by Neel and Valentine, a figure which is surprisingly high 11 In both forms of thalassemia and in sickle cell anemia there is evidence of increased erythrocyte destruction despite the fact that the cells are thin and resistant to hemolysis in hypotonic saline 12

Paroxysmal nocturnal hemoglobinum is a rare but fascinating disease. Here again the defect resides within the erythrocyte which, although morphologically normal and having normal resistance to hypotonic salt solutions, is highly sensitive to slight decreases in the pH of its environment. According to Ham, hemoglobinemia is constantly present but becomes sufficiently severe to produce hemoglobinum at night as a result of slight increase in the acidity of the blood during sleep. 13

There are still other varieties of hemolytic anemia in which the erythrocytes lack distinctive morphology but transfusion studies have shown them to be defective 4,14 For the time being it seems best to label such cases merely as "atypical"

# Role of the Spleen

It is generally conceded that the spleen is not essential to the maintenance of health and that

it is much more important pathologically than physiologically Its pathologic activities may be of at least three varieties phagocytic, "hormonal," and mechanical Reference has already been made to the occurrence of excessive phagocytosis of red cells, white cells, and platelets. a phenomenon which may be selective or total in the latter case, the result is "panhematopenia" Dameshek<sup>15</sup> has been more impressed with the apparent inhibitory effect of the overactive spleen upon the bone marrow than with phagocytosis within the spleen, and he suggests that the spleen may elaborate one or more hormones controlling maturation and delivery of red and white cells and platelets in the marrow Despite the fact that such regulatory substances have not been isolated this hypothesis receives indirect support from a number of recent clinical and laborators observations

Splenectomy has been dramatically successful in certain illnesses characterized by splenomegaly, hyperplastic marrow, and diminution of one or all formed elements of the blood Regardless of whether the spleen produces this clinical picture by reason of its phagocytic activity or by excessive elaboration of humoral substances inhibiting the delivery of cells and platelets from the marrow, the fact remains that splenectomy may be beneficial <sup>16</sup> It is, therefore, important that the various forms of hypersplenism be differentiated from aplastic anemia and "toxic" or "allergic" agranulocytosis and thrombopenia. In making these distinctions examination of the bone marrow is essential

The phagocytic and the possible humoral activities of the spleen are elusive subjects for investigation, but obviously deserve intensive study in the years ahead The mechanical action of the spleen, upon red cells at least, is more readily demonstrable and has become more clearly understood as a result of recent obser-On the basis of their work with transilluminated mammalian spleens. MacKenzie, Whipple, and Wintersteiner 16 have presented the diagram of splenic circulation shown in In the relaxed spleen, blood flows from the arterioles into the pulp spaces where stagnation and hemoconcentration occur, and the cells are thus separated to some extent from the antihemolytic effect of plasma During their stay in the pulp, even normal red cells become thicker, and in congenital hemolytic anemia the defective red cells become still thicker and more fragile 17,18 It is relatively easy for discordal cells to pass from the pulp through the slit-like openings in the venous sinusoids, but the very thick, spherocytic cells cannot escape so readily It appears that they may be retained

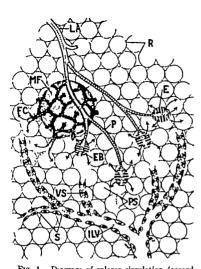


Fig. 1 Diagram of splenic circulation (according to Mackenzie Whipple, and Wintersteiner is reproduced by courters of Wistar Institute of Anatomy and Biology) LA lobular artery MF malpighian follide, P penicillus, FC follide capillary E cilipsod EB lateral channel in wall of ellipsoid, R red pulp reticulum PS pulp spaces, VB venous sinus ILV intra lobular vein B stigmata in walls of venous sinus and intralobular vein

in the pulp in intimate contact with phagocytic cells which destroy them, or eventually they may escape only to be destroyed elsewhere in the body <sup>10</sup>

The selective action of the spleen upon abnormal cells of patients with congenital spherocytic hemolytic anemia has been studied recently by Emerson, Shen Ham, and Castle, 17 and their observations have been confirmed in our labora tory at the Strong Memorial Hospital 18 Normal cells of types which could be differentiated from those of the recipients were transfused to these patients a few days prior to splenectomy Immediately after operation red cells were washed from the splenic pulp and it was found that most of the erythrocytes trapped in the pulp were the patient s own cells the proportion of donated corpuscles in the peripheral blood being much higher than in the spleen The fragility (ocmotic and mechanical) of the normal donated cells was normal in the peripheral blood and only slightly increased in the spleen, while the fragulty of the patient s own cells was much greater in the splenic pulp than in the peripheral blood. It appeared that the inherently defective cells of these patients were selectively retained in the splenic pulp and that the thickness and fragility of these cells were somehow selectively increased

That this selective action upon abnormal ervth rocytes is due to defectiveness of the cells rather than to any specific abnormality of the spleen in congenital hemolytic anemia seems likely in view of our recent perfusion experiments 18 Cells from a splenectomized individual with the congenital spherocytic defect were mixed with normal cells of a different type and perfused through the arteries of a spleen immediately after its removal from a patient with idiopatine thrombopenic purpura It was found that the abnormal cells were selectively removed from the mixture, and at the end of perfusion these cells were found densely packed in the splenic pulp despite the fact that the spleen had been removed from a patient whose disease was not hemolytic anomia but thrombopenic These observations together with purpum Dacio's perfusion studies of a different type 20 make it seem possible that a perfectly normal spleen might selectively retain defective cells in its pulp \*\*\*

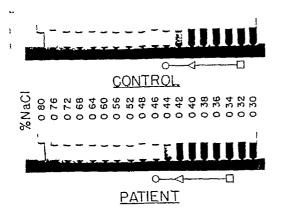
### Laboratory Tests

It is appropriate to consider next some of the more useful laboratory procedures based upon the newer concepts of hemolytic mechanisms which have just been reviewed

Osmotic Fragility -It is well known that in the majority of cases of concenital hemolytic anemia the fragility of the red cells in hypotonic saline is increased. This test has definite limits. tions from the diagnostic standpoint however, since increased fragility together with spherocytosis may be found in certain acquired cases On the other hand there are some patients with the congenital disorder whose red cells have normal or nearly normal fragility even when tested by sensitive methods employing a photoelectric colorimeter to measure the degree of hemolysis in each tube of salt solution is particularly true of persons whose disease is quiescent but whose blood may be under close scrutiny because of family relationship to a patient suffering from an active hemolytic pro-CERR

As a result of the observation by Ham and Castle<sup>11</sup> and Emerson Shen Ham, and Castle<sup>12</sup> that cells incubated in vitro at body temperature

<sup>\*\*\*</sup> Although the trapping or mechanical effect of the splena I considered of great importance in the pathogenesis of congenital hemolytic anomia, it is acknowledged that a complete explanation of all of th pile mean of this disease is not yet at hand. The era t cause of h molytic crises is particularly mystations.

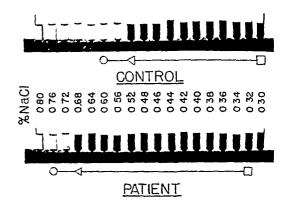


# FRAGILITY OF <u>FRESH</u> RED CELLS IN HYPOTONIC SALINE

Fig 2 Hemolysis of fresh red cells in hypotonic saline

have increased fragility, improved methods of measuring this change are now being developed The usefulness of the modified fragility test is illustrated in Figs 2 and 3 The circles in these figures indicate the tubes in which hemolysis begins, the triangles the tubes in which hemolysis becomes marked, and the squares indicate the tubes in which hemolysis is complete In Fig 2 the results of a test on fresh normal cells are compared with those obtained with fresh cells from a patient with congenital hemolytic anemia Although the latter cells appear to be slightly more fragile, the difference is not significant When the two samples of blood were incubated for twenty-four hours at body temperature and retested, the difference in fragility was very marked, the normal cells having undergone a modest increase while the defective cells from the patient showed a far greater increase

In recent months we have tested the fragility of both fresh and incubated erythrocytes from 18 patients with the congenital defect and from 4 patients with atypical or acquired hemolytic Our results to date suggest that a anemia marked increase in fragility with incubation may prove to be rather specific for the congenital disorder Indeed it appears that in vitro incubation may produce essentially the same change in the defective erythrocytes of this disease as is produced in vivo in the splenic pulp It is particularly useful to apply the incubation test to cells from close relatives of patients suspected to have congenital hemolytic If this disorder is inherited as a Mendelian dominant, the cellular abnormality should be demonstrable in one of the two parents of each patient In some cases, however, the



# FRAGILITY OF INCUBATED RED CELLS IN HYPOTONIC SALINE

Fig. 3 Hemolysis of incubated red cells in hypotonic saline. Note that tubes above 0.48 per cent NaCl are spaced at intervals of 0.04 per cent defect may be apparent only after incubation, if at all

Mechanical Fragility —Determination the mechanical fragility of erythrocytes22 23 appears to be distinctly worth while in studying patients with certain types of hemolytic anemia The procedure described by Shen, Castle, and Fleming<sup>22</sup> is carried out by placing a small amount of oxalated or defibrinated blood in an Erlenmeyer flask containing glass beads The flask is then rotated as shown in Fig 4, thus subjecting the cells to a standard amount of The hemoglobin liberated from the cells during this period is measured and compared with controls which have been subjected This test is to the same amount of trauma attractive on theoretic grounds for the obvious reason that it subjects cells to the sort of mechanical buffeting which they doubtless receive in circulation

It has been found 17 18 23 that the mechanical fragility of erythrocytes freshly drawn from patients with congenital hemolytic anemia is significantly greater than that of normal cells When the test is carried out on corpuscles which have been incubated, there is usually a moderate increase in the mechanical fragility of normal cells while corpuscles from patients with the congenital spherocytic defect show a very marked increase Here again incubation aids materially in demonstrating the difference between normal and pathologic cells nature of the change occurring in erythrocytes with incubation is not understood, but the increases in thickness and volume and in both osmotic and mechanical fragility of cells incubated in vitro are comparable to the changes

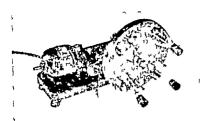


Fig. 4 Rotator used in testing mechanical fragility of crythrocytes.

observed in cells which have been trapped in the splenic pulp. It appears that further study of the effects of in vitro incubation of crythrocytes may throw considerable light upon the mechanism by which these cells are unfavorably altered by the spleen

In a few cases of a typical hemolytic anemia, increased mechanical fragility of crythrocytes has been demonstrated even though the osmotic fragility was normal or actually decreased in It is also of interest that increased mechanical fragility has been observed in the presence of cold agglutinins and isoanglutinins and in experiments with sickled cells if Further study will be necessary before the clinical applications of this new and interesting laboratory procedure can be fully stated

Serologic Tests — Among the sorologic manipulations which have proved most useful in studying hemolytic disorders are the simple presumptive tests recommended by Ham<sup>24</sup> and outlined in Fig 5 Fresh defibrinated blood is placed in each of three tubes. The first tube is placed in each of three tubes. The first tube is incubated at body temperature then centrifuged if hemoglobin is present in the supernatural serium presence of a warm hemolysin is suggested and a more elaborate test with suitable controls is made.

The second tube is chilled in cracked ice, then incubated and contrifuged This is the Donath-Landsteiner test which, if positive and confirmed by a more complete procedure indicates that the patient is probably suffering from paroxysmal cold hemoglobinuma In this curious, malady which is nearly always associated with syphilis, antibody becomes attached to red cells at low temperature, and in the presence of complement hemolysus occurs when the blood is warmed is presumed that a similar reaction takes place in vivo thus causing hemoglobinuris when the patient is warmed indoors after chilling outdoors. When the Donath Landsteiner test is carried out the presence or absence of cold agglutinins can often be determined by examining the chilled INCUBATE 1-2 HRS.
THEN CENTRIFUGE

CHILL 20'
THEN INCUBATE 1 HR
THEN CENTRIFUGE

THEN CENTRIFUGE

JEMOLYSIS ROCATES,
PRESENCE OF WARM
HEMOLYSINS

PAROXYSMAL COLD
HEMOGLOBINIRIA

ACIDIFY WITH CO.
THEN INCUBATE I HR
THEN CENTRIFUGE



Fig 5 Presumptive tests for warm hemolysins cold hemolysins and send fragility

blood for agglutination before it is warmed. If only cold agglutinins are present clumping disappears when the blood is warmed and no hemolysis occurs Cold agglutinins have been observed in a variety of conditions but notably in atypical pneumonia and in some cases of hemolytic anemia both congenital and ac quired " Since the mechanical fragility of agglutinated crythrocytes is increased it is not unreasonable to suppose that these antibodies may cause hemolysis in vivo when blood is cooled in the extremities of the body be pointed out however that the exact significance of cold agglutining is not yet clear and that much more complicated tests than those described here are necessary in order to characterize the agglutining in any given case

In the third tube of the series under consideration is placed fresh defibrinated blood which has
been acidified with carbon dioxide. If hemolysis
is apparent after centrifugation a more elaborate
test with controls is carried out to confirm or
disprove the diagnosis of paroxysmal nocturnal
hemoglobinum. It can be demonstrated that
the defect in this disease is in the crythrocyte
since fresh normal sorum can be substituted for
the patient's serum in carrying out the acid
hemolysis test. If normal cells are mixed with
the patient's serum however, the result is always
negative

In the investigation of hemolytic disorders prior to 1944 sorologic tests were designed to demonstrate hemolysins and agglutinins only Since the discovery of blocking antibodies by Wiener<sup>14</sup> and Race<sup>21</sup> in that year, additional tests have been developed which apply particularly to the Rh factor but have applications in the study of other hemolytic diseases as well Highly diagrammatic aketches of the possible antibody red cell relationships in these newly discovered reactions are shown in Figs. 6 and 7 Agglutinins, which are thought to be bivalent or multivalent antibodies, may be regarded as

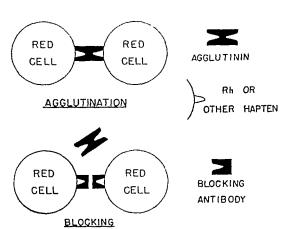


Fig 6 Agglutination and blocking reactions (modified from drawings by Wiener<sup>28</sup>)

attaching themselves to Rh or other haptens on the red cells and thus bringing about agglutination somewhat as sketched in Fig 6. The exact nature of this reaction is not understood. There are, moreover, many haptens on each red cell, and the reaction between these factors and agglutinins in the serum is three-dimensional. It should be stressed that the illustration is greatly simplified.

Blocking antibodies are regarded as univalent or incomplete and by themselves they are incapable of causing visible clumping of cells. When they are attached to erythrocytes, however, their presence may be detected by adding a known agglutinating serum which then fails to cause agglutination because the blocking antibodies are already attached to the specific red cell receptors. Despite the fact that incomplete antibodies by themselves are unable to cause agglutination in vitro, they are responsible for the majority of cases of hemolytic disease of the newborn and perhaps other types of hemolytic anemia.

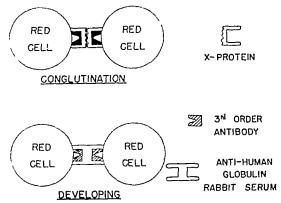
Incomplete antibodies may be demonstrated more easily by means of the so-called "conglutination" test, first described by Wiener and illustrated in Fig 7. A serum containing such antibodies is mixed with Rh positiv', cells suspended in plasma, serum, or a concentrated albumin solution instead of in saline. The proteins (X-protein of serum) of these suspension media are somehow able to produce clumping of cells sensitized by the univalent antibodies to the light of the transfer of the sensitized by the univalent antibodies to the light of the light of the light of the sensitized by the univalent antibodies to the light of 


Fig 7 Conglutination and developing reactions The conglutination reaction is sketched according to Wiener's concept <sup>28</sup>

transfusion, particularly in cases in which the recipient is thought to be sensitized to the Rh factor. The simple expedient of suspending the donor's cells in his own serum rather than in saline before mixing with the recipient's serum may detect otherwise inapparent sensitization of the recipient and may actually be life-saving.

Since the incomplete antibody, like the agglutinin, is a gamma globulin, its presence on a red cell can be detected by still another test which employs serum from rabbits immunized with human gamma globulin 29 The antiglobulin serum causes agglutination of washed erythrocytes to which human globulin is adsorbed specifically This procedure which detects not only blocking antibodies but also globulins referred to as "third order" antibodies, has been named the "developing test" by Hill and Haberman<sup>30</sup> because of the analogy to photographic development Although the exact clinical significance of third-order antibodies (shown with cross-hatching in Fig 7) is not yet clear, it has already been demonstrated that the usefulness of the developing test is not limited to the Rh It has been found 18,31, 32 that cells from patients with certain types of acquired hemolytic anemia are regularly agglutinated by the rabbit serum, presumably because an antierythrocyteglobulin is adsorbed to these cells Serum from such cases may contain no demonstrable agglutinins or hemolysins, but immune bodies, perhaps of the "third order," nevertheless, are fixed to the red cells of the patient and the cells may continue to give positive reactions even during remission following splenectomy rocytes from patients with intracorpuscular defects, on the other hand, give negative reactions with rabbit serum, as might be expected It is likely that this simple test will prove helpful in differentiating congenital spherocytic anemia from certain acquired cases, a differentiation which is sometimes difficult on clinical grounds

<sup>†</sup> It should be emphasized that nomenclature in this field is unsettled. At the International Hematology and Rh Conferences held in Dallas Texas and Mexico City in November 1946 the use of the terms \protein and conglutination was rejected (News and Views Blood 2 204 (March) 1947) These terms have been employed in this paper however because of their frequent appearance in recent literature

TABLE 2 -CLASSIFICATION OF RIN BLOOD TYPES (ACCORDING TO WIENERS)

	REACTION OF CELLS WITH RY TYPING SERA ANTE I ANTI   ANTI			DISTRI-	RIL JESTIN' WITH ANTI-RIL
Rb TYPE	Rh	fih	Rho	_%	SERUM
Ph.	_	-	-	13.0	
Rh-	+	-	-	10	145%
Rh	-	+	-	0.5	Rh
Rh RH	+	+	-	0.01)	I
rh <sub>0</sub>	-	-	+	20	١
Rh, (Rho)	+	-	+	54 0	85 5%
Rive (Rive)	- '	+	+	15.0	Rh+
RON Rhy	+	+	+	145	)

Since splenectomy is uniformly beneficial in the congenital disease and somewhat of a gamble in the acquired disease the rabbit serum test may prove to have prognostic value. It obviously deserves further study

#### Prevention

Among the most important recent advances in the prophylaxis of hemolytic diseases are those pertaining to the Rh factor There is an understandable tendency among clinicians to shrink from consideration of the increasingly complex Rh-Hr system, but actually the essential features of the problem are relatively simple and can be stated briefly Rh typing is carried out as outlined in Table 2, by use of three antisera which distanguish eight Rh types.28 This procedure is largely of academic and medicolegal interest, however, and the clinician will do well to focus his attention on Rh testing which is done by mixing cells with an anti Rho serum alone This is the only variety of Rh antiserum avail able commercially and is the only variety needed for ordinary hospital use. The 15 per cent of white individuals whose cells contain only the Rh' or Rh" factor give negative reactions with the standard or anti Rhe serum and should be handled clinically as though they were Rh negative

It is now appreciated that the cells of all blood doors and all recipients should be tested for the Rh factor and that Rh-negative recipients should be given only Rh-negative blood except in emergencies. Such a polley will not only prevent ultimate hemolytic reactions to transfusion among recipients of both sexes but it will also prevent unnecessary sensitisation of Rh negative fermale recipients who are potential mothers. Sensitisation to the Rh factor may persist for many years, perhaps for life. 31 An Rh-negative woman who has been transfused with Rh-positive blood, even in early childhood may

therefore less her first child as well as subsequent children, due to development of erythroblastosis fetalis. This tragedy may be prevented to a large extent, at least in the firstborn, by adhering rigidly to the policy of transfusing only Rh negative blood to Rh-negative recipients.<sup>12</sup>

Fortunately at least 05 per cent of Rh negative women with Rh positive husbands do not have crythroblastotic children, fland this fact should be made clear to the many couples whose fears have been unnecessarily aroused by carelessly worded articles in the lay press. Once a Rhnegative woman has had a child with crythroblastoss, however, there is no certain method by which the development of this form of hemolytic disease can be prevented in subsequent Rh positive children. Here is indeed a fertile territory for investigation

Recent studies on the anti-A and -B agglutiums have shown conclusively that excessive use of universal donors, and also of plasma, may cause appreciable destruction of recipient's cells.<sup>3</sup> - <sup>34</sup> Fortunately this hazard can be eliminated by neutralizing the anti-A and B agglutinias of group O blood with small amounts of a solution of A and B factors—a procedure which Klend shop and Witebsky- <sup>34</sup> have shown to be safe and of particular value in emergencies when accurate trying cannot be done

Although blackwater fever is rarely seen in New York State it should be mentioned here that this serious complication of falciparum malaria can be prevented effectively by recognized antimalarial measures

#### Treatment

Aside from eradication of such extrinsic agents as parasites and chemicals, the only forms of specific therapy for hemolytic anemias are transfusion and splenectomy. One of the important contributions of wartime research was the demonstration that whole-blood transfusions are essential in the management of severe burns and that the anemia in these cases is due in part to a brief period of rapid red cell destruction 44 ft With regard to the treatment of erythroblastosis fetalis Wiener et al 42 and Wallerstein 44 have shown that exchange transfusion, in which most of the infant's blood is replaced by Rh negative blood may be dramatically successful in selected cases, especially when carned out during the first few hours of life. The exact indications for this rather drastic procedure are not vet clear Transfusions are sometimes

<sup>††</sup> According to Dr. Donald H. Karlber of Rochester New York (personal communication) only 1 of 33 Rh-negative women with Rh-positive husbands has hildren with crythroblastosis (stalis. The experience f other investigators is similar.

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necessary and temporarily beneficial in the hereditary hemolytic disorders, but in this aspect of therapy there are no recent developments which have been evaluated adequately

Splenectomy almost invariably produces marked improvement in patients with congenital spherocytic hemolytic anemia, provided any accessory spleens are removed as well as the mother spleen Jaundice disappears and the red cell count uses to normal following operation. but the erythrocytes, nevertheless, remain defective and one night guess that if a normal spleen could be transplanted into such a patient, rapid red cell destruction would again be ob-In contrast to the favorable results obtained in patients with the congenital spherocytic defect, splenectomy is without value in sickle cell anemia, thalassemia, and nocturnal hemoglobinuria

One of the most important recent advances in the treatment of hemolytic disorders is the recognition of the fact that splenectomy may produce dramatic results in some of the acquired or atypical cases, and in those included under the term "hypersplenism" Since there is relatively little to lose by splenectomy and much may be gained, it is unwise to delay operation beyond the period necessary for carrying out essential diagnostic procedures Unfortunately. however, the prognosis must always be guarded for a considerable time in these cases because many show little or no improvement following operation There is great need for intensive study of this heterogeneous group of hemolytic anemias in order that adequate criteria for splenectomy may be formulated

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# DIAGNOSIS OF CORONARY THROMBOSIS

Steincrohn\* called attention in 1940 to a new observation said to be helpful in the diagnosis of coronary thrombosis, namely the rhythm and periodicity of the pain as the most characteristic feature of the syndrome. This periodicity holds true for indefinite attacks as well as for those in which the pain and shock are so prominent that the diagnosis is unquestioned According to him the pain comes and goes in cycles Morphine should not be withheld when the patient is first seen in an attack, since the pains will continue to recur and remain recogniz-

able before the morphine exerts its full effect. Steincrohn found this pain syndrome invaluable in ruling out the presence of extracardiac anginas such as acute gallbladder disease, ruptured peptic ulcer, actue pancreatitis, intestinal obstruction, acute pneumothorax and pulmonary embolism or infarct. The cause for the recurring pains is not clear

Theoretically the symptom might be AIplained on the basis of the changing level of anovemia, which is dependent on the adjustments which the cardiac circulation is called on to make in the first few hours following the immediate shock of the attack—Editorial, JAMA June 7, 1947

A New Obervation Helpful in the Drag-\* Steincrohn P J nous of Coronary Thrombons Ann. Int Med 14 495 (Sept.) 1940

### CLINICAL MANIFESTATIONS OF HODGKIN'S DISEASE\*

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THE clinical features of Hodgkin's disease I need no special emphasis when they conform to the textbook description of the fully developed malady Swelling of the glands of the neck is the hallmark of the condition Pruntus, ma laise, weakness, fever and weight loss are the usual complaints. Men are affected more frequently than woman and the highest in cidence is in the middle decades of life  $\lambda$  ray examination of the chest may reveal hilar or mediastinal enlargement. From two to ten years after the onset of symptoms, the patient dies from cachexia, an intermittent infection, or

from pressure on vital structures

There are many clinical variations of the above description, particularly in the earlier phases A significant percentage of patients with Hodgkin's disease either do not present this typical picture or present this typical picture with one or more unusual and additional manifestations Hence, one of the motives in the preparation of this communication is to stress the vagaries of this condition Second, such a discussion is timely in view of the frequent admission to a general hospital of patients with this disease The increasing number of patients seen on the wards suggests that the disease is recognized earlier now in comparison with a generation ago Third, a new form of therapy, nitrogen mustard has been made available recently and it is appropriate that this subject be considered before this assembly

Fourteen patients with Hodgkin's disease were admitted or readmitted to the Buffalo General Hospital in recent months. Six of this number were unusual in one or more aspects This group has provided interesting clinical data that will be discussed in reference to each individual case. The first patient has had a benign form of the malady and has had few typical symptoms while under observation for a period of more than four years. The second patient had a diagnosis of Kaposi a sarcoma of the skin made several months prior to the appearance of enlarged glands. The third patient had a profound anemia and at autopsy showed extensive bone marrow infiltration. The fourth

patient had pruntus and a generalized skin cruption several months preceding the suspicion of Hodgkin's disease. The fifth patient had chronic jaundice hepatomegaly and splenomeg aly for more than two years The sixth patient had a high percentage of cosmophils in the peripheral blood Two of the patients were treated with nitrogen mustard with minimal improvement.\*\*

## Case Reports

Case 1 -R. II., a woman, aged 58 was admitted to the hospital in 1942 complaining of cardiac symptoms. A diagnosis of chrome valvular heart disease rheumatic in cause was made. In obtaining the history the patient stated that the glands in her nock had been enlarged for a few weeks. The physical examination revealed in addition to the cardiac findings adenopathy in the cervical axillary and inguinal regions. The liver and spleen were not felt. Scattered over the body were lesions that the dermatology service considered to be crythems multiforme. The laboratory studies were not remarkable except for a slight leukocytosis. There was no evidence of hilar enlargement of the chest by x ray A skin biopsy was considered to be consistent with crythema multiforme. The biopsy of a cervical node showed simple inflammatory hyperplasia. The patient's primary complaints were cardiac and in the absence of a pathologic or clinical diagnosis of Hodgkin's disease no x ray therapy was advised

The following year the patient was admitted to a cancer hospital on the advice of her local physician In that institution another biopsy was taken from the cervical chain of glands and Reod-Sternberg giant cells were observed. X-rays of the chest at this time showed mediastinal enlargement. A long course of radiation therapy was given which was repeated on two occasions. Follow up x-rays of the chest six months after discharge were negative for mediastinal glands.

The patient was readmitted to the Buffalo General Hospital on several occasions in 1946 and 1947 and in each instance the complaints were cardiac. The generalized glandular adenopathy permeted. There was no febrile reaction at any time that was

attributable to Hodgkin a disease.

Comment -This patient had had minimal but generalized glandular adenopathy for approximately four years A biopsy of a cervical gland in 1943 was characteristic of Hodgkin's disease Radiation therapy was followed by disappearance of the

Presented by invitation, at the 141st Annual Meeting of the Medical Society of the State of New York Buffalo General Sessions, Symposium on Hematology May 9 1947

These studies were supported in part by a generous con-tribution from Mrs. Kathleen Chard of Chestnut Hill Mass achusette.

<sup>\*\*</sup> The author is indebted to Drs. Stuart Vaughan, A. H. Aaron, and Earl Osborne for referring one or more of these cases to the hospital

glands in the mediastinum and reduction in size of the superficial glands. The mild clinical course, absence of fever, and no enlargement of the liver and spleen suggest the benign form of the disease which has been designated by Jackson and Parker<sup>1</sup> as Hodgkin's paragranuloma

Case 2—M S, a woman, aged 56, was admitted to the hospital twice in 1935 At the first admission a diagnosis of hypertensive heart disease and rheumatoid arthritis was made. The blood pressure varied between 190/110 and 200/130 A few weeks later she was admitted because of painless jaundice which was believed to have been associated with an attack of catarrhal hepatitis. In the following six years she had frequent epistaxis and the blood pressure when taken was in the hypertensive range.

Early in 1946 she was seen in the dermatology clinic for unusual skin changes A diagnosis of Kaposi's disease was made at this time This was treated by radiation with little or no improvement In June, 1946, she was admitted to the hospital because of lumps in the right axilla. On physical examination she had a low-grade fever and a blood pressure of 230/120 In the supraclavicular, avillary, and inguinal regions there were chains of glands Over both upper and lower extremitics there were many reddish-purple circumscribed papular lesions that were neither itchy nor painful. The laboratory studies of the blood and urine were normal The 1-ray of the chest was negative for mediastinal enlargement A barrum meal showed a pressure defect on the stomach and the possibility of a retroperatoneal mass was postulated biopsy of the avillary gland showed changes characteristic of Hodgkin's disease and 1-ray therapy was The general condition was essentially unaltered in the following six months

The patient was readmitted late in 1946 for a course of nitrogen mustard treatment ized glandular adenopathy was present purplish skin lesions had spread slightly The red blood cell count varied between 34 and 38 million, the white blood cell count prior to giving nitrogen mustard was 3,600 with an essentially normal dif-The sedimentation rate was norferential count The 1-ray of the mal The patient was afebrile chest showed no hilar enlargement Four intravenous injections of nitrogen mustard were given with few untoward symptoms. On discharge the blood studies were similar to those on admission The patient believed that she was better subjectively At no time in the following months did the glands or skin lesions subside appreciably

Comments—This case is an instance of Hodg-kin's disease in which superficial glandular adenopathy was preceded by evidence of Kaposi's skin sarcoma. The chronologic association between these two maladies was fairly close but the etiologic association is difficult to establish. Although a variety of skin manifestations accompany or precede glandular Hodgkin's disease, reticuloendothelial tumors with formation of blood vessels have received scant attention in current available literature. In a series of 63 patients with Kaposi's disease, not a single instance of associated Hodgkin's

disease was noted by Choisser and Ramsey: Hence, if these conditions coexist it is believed to be an unusual situation

Case 3 -H C, a man, aged 45, was first admitted in June, 1946, with complaints of swollen glands, thills, fever, cough, dyspnea, weakness, palpitation, and a 30-pound weight loss over a two-year period. On physical examination the patient was febrile and pale, there was marked enlargement of the cervical glands and moderate enlargement of the axillary glands. The liver edge was palpable at the umbilious and the spleen was palpable 4 cm. below the costal margin The red blood cell count was 3 3 million, the white blood cell count was 10,500 with a differential that was essentially normal sedimentation rate was clevated markedly The x-ray examination of the chest was negative lymph node biopsy was suggestive but not diagnostic of Hodgkin's disease Following 1-ray therapy the fever subsided and the patient improved subjec-

The patient was readmitted in October, 1946, because of increasing weakness and a chronic cough The anemia had become worse and had responded only to repeated transfusions of the chest at this time showed enlargement of the hilar shadows with a mass in the superior mediastınum The size of the liver and spleen was un-The spiking temperature had returned changed Following five injections of nitrogen mustard the superficial glands, liver, and spleen decreased considerably in size, and the 1-ray of the chest showed diminution in size of glands in the mediastinum The temperature was normal on discharge

The final admission was in January, 1947 subjective improvement following nitrogen mustard had persisted for two weeks only swelling of the glands, chills, and fever returned promptly In addition, there was swelling of the abdomen and legs from ascites and edema, respec-On physical examination the liver was unchanged in size while the spleen was 6 cm below the costal margin The examination was otherwise as noted above The laboratory studies showed a profound macrocytic anemia and a leukopenia as low as 2,500 with not more than 10 per cent lymphocytes The sedimentation rate was markedly elevated Re-examination of the chest by x-ray showed an extension of the hilar and pulmonary parenchy mal involvement The patient continued to have a spiking temperature and tachycardia, and in spite of further x-ray therapy to the mediastinum, died in February, 1947 The autopsy examination showed generalized Hodgkin's disease which included involvement of the lymph nodes, lungs, liver, spleen, kidneys, and bone marrow

Comment—The general dissemination of the granulomatous tissue is of clinical significance in this case. In this small series this is the only patient having Hodglin's disease who is dead or even acutely ill. The appearance of a profound anemia which did not respond except to whole blood transfusions was a grave prognostic sign. Undoubtedly the extensive bone marrow involvement was responsible for the depression in blood formation.

Profound anemia is not a frequent accompaniment of Hodgkin s disease except in the fulminating stage Uchlinger! has attached considerable significance to the leukopenia which may be a result of bone marrow infiltration. It is of note that in this patient a slight leukocytosis was observed at the first admission but subsequently a leukopenia with an increase in percentage of polymorphonuclear cells developed. The liver and spleen were grossly enlarged on the first admission the enlargement was confirmed at the postmortem examination

Case 4 - 1 W a man, aged 54 was first admitted in August 1046 for a generalized bullous crythema tous lesion of only a few days duration acutely ill on admission had a temperature as high as 102 F., and skin lesions that were considered to be erythema multiforme by the dermatology service In addition, there were a few small glands in the supraclavicular area on the right the enlargement of which was attributed to the cutaneous involvement The white blood cell count was 10 000 with 50 per cent bands and 41 per cent filaments. The labora tory studies were otherwise negative. The nationt improved slightly during a ten-day hospital stay but was discharged without the temperature having returned to normal General supportive measures only were prescribed and the possibility of this being associated with a lymphoblastoma was not considered seriously

The patient was readmitted three months later because of increasing weakness, malaise, swelling of the face and persistent skin lesions Extensive lymphadenopathy of the cervical, axillary and inguinal areas was present. There was massive odema of the face and swelling of the parotid glands. The liver was palpable 2 cm. below the costal margin and the spleen was palpable 4 cm below was an crythematous papular skin rash over the The dermatology service did not alter their diagnosis of ethythema multiforme. The red blood cell count was 4,2 million the white blood cell count was 16 000 with a differential of bands 38 per cent, filaments 40 per cent, cosinophils 11 per cent, and lymphocytes 9 per cent The sedimentation rate was normal. The patient was acutely ill and an overwhelming disease such as acute disseminated lupus was considered on admission

The x-rays of the chest, however showed bi lateral hilar node involvement and Hodgkin's discase was suspected. The pathologic report of a skin and muscle biopsy respectively showed inflammatory granulomas surrounding the venous capillaries. The nodular arrangement of the cells was auggestive of specific granulation tissue. No Reed-Sternberg giant cells were seen The biopay of an axillary gland showed chronic inflammatory hyperplasia of the lymph node with the original structure entirely obscured There was a moderate number of ecsinophils and a number of plasma cells. It could not be determined whether or not the diffuse hyperplasia with reticulum cells involved pointed to an early manifestation of Hodgkin s discase There was nothing to suggest lymphosar

Since the clinical picture was highly suggestive of

Hodgkin's disease the patient was given a course of x ray therapy to the cervical and upper mediastinal nodes. Marked subjective and objective improvement followed, the temporature fell and a gain of several pounds of body weight was recorded in spite of a loss of considerable edema fluid. Yeary treatment has been continued up to the present and the patient remains essentially symptom free.

Comment—The diagnosis of Hodgkin's disease cannot be established unequivocally in this patient in the absence of pathologic findings of Reed-Sternberg cells. On the other hand the clinical picture on the second admission included the following fea tures pruritus generalized adenopathy hepatomegal, splenomegal, fever hilar and mediastinal culargement by x ray and biopsies of skin, muscles and glands which excluded other reasonable possibilities. Finally, the response to radiation treat ment was dramatic and has persisted. This patient is discussed in this report because of the pruritus and skin involvement which preceded glandular adenopathy of clinical significance.

Case 5 -S S. a woman aged 49 had a four year story of fatigue weakness, jaundice abdominal soreness and pruntus. She was admitted to another hospital in 1944 because of a weight loss of 30 pounds. A laparotomy was performed and enlargement of the liver and spleen was noted. The liver biopey showed an obstructive type of jaundice A lymph-node biopsy was suggestive but was not specific for Hodgkin 8 disease. The patient was discharged without a satisfactory diagnosis after six months in the hospital and no specific therapy was recommended. The fact that x ray therapy was not given suggests that the diagnosis of Hodgkin s disease was not entertained seriously discharge the patient remained in bed a great deal She had chills and fover at times discomfort in the splenic area, and pruritus with jaundice.

On admission to the Buffalo General Hospital in January 1947 the patient appeared well developed but chronically ill There was general bronzing of The sclerae were vellow There were a few small glands in the cervical and supraclavicular region The liver was markedly enlarged and the spleen was felt 5 cm, below the costal margin. The red blood cell count varied from 3 8 to 4 0 million The white blood cell count varied from 3 600 to 4 600 There were 26 per cent lymphocytes and 6 or cent cosmophils The cephalin flocculation and thymal turbidity tests were negative. The van den Berg concentration was as high as 1 2 mg. per cent The alkaline phosphatase varied from 27 to 34 unita. The serum globulin concentration was 2.9 Gm The stools were brown in color The fragility test was normal. The x ray examination of the chest and stomach was negative. A biopsy of a cervical gland showed changes typical of Hodgkin's disease and x ray treatment was started. Thereafter she began to gain weight and strength. She was not febrile during the six weeks hospital stay

Comment.—This is the record of a patient with low-grade jaundice enlarged liver and spleen, and no satisfactory diagnosis for a prolonged period of time. The possibilities on admission in 1047 included cirrhosis of the liver, Banti's syndrome, hemolytic jaundice, and hemochromatosis. Only after the several laboratory studies had failed to confirm each of these was a gland removed for examination and the presence of Hodgkin's disease substantiated. It is most likely that this malady has been responsible for the patient's symptoms during the past four years. The general improvement following radiation is confirmatory.

Case 6 -E L, a man, aged 39, complained of anorevia, a 40-pound weight loss, chills, fever, and sweating of four months' duration The physical examination revealed one gland in the supraclavicular space 1 cm in diameter, a few small cervical nodes, and palpable epitrochlear glands edge was felt at the costal margin The red blood cell count varied from 36 to 42 million white blood cell count varied from 37,800 to 48,500, the cosmophils varied from 33 to 45 per cent, and the lymphocytes from 7 to 11 per cent The sedimentation rate was elevated markedly tination tests for several organisms were negative The complement fixation test for trichino is was Serum globulin ranged from 29 to 35 negative Gm per 100 cc

The \-ray of the chest showed masses in both hilar regions, extending posteriorly into the mediastinal area to within three inches of the diaphragm From the roentgen appearance, the findings could be attributed to either a neoplastic or an inflammatory The aspiration of the bone marrow showed a macrocytic anemia and a 33 per cent eosinophilia The pathologic examination of the gland taken from the supraclavicular space was characteristic of Hodgkin's disease The biopsy of the muscle from the thigh showed no evidence of parasites and nothing to suggest periarteritis nodosa. The patient had a high spiking temperature (98 - 105 p r ) during the ten days of hospitalization The pulse rate varied from 80 to 130 At no time did he appear toxic or as acutely ill as his temperature would suggest He was discharged for x-ray therapy in his home town

Comment—Because of the high eosinophil count (33 to 45 per cent) in the blood and bone marrow, the clinical impression initially was either trichinosis or periarteritis nodosa. When laboratory, evidence in support of either of these possibilities was not forthcoming, a gland was removed for examination, and this showed Hodgkin's disease. Eosinophilia has been observed in this malady but is usually less than 10 per cent of the total leukocytes and is not associated with a high leukocytosis.

# Discussion

Many of the characteristic symptoms and findings of Hodgkin's disease have been enumerated in the discussion of the 6 cases. Each of the patients had generalized lymphadenopathy and in each instance the cervical glands were involved. Unexplained development of cervical or other glands should be a warning either to a patient or doctor and should be the object of as careful study as that given in instances of hemor-

rhage, pain, or loss of weight-symptoms that frequently send a patient to the physician to exclude cancer Furthermore, according to Jackson and Parker, "Any lymph node materially enlarged over a period of time and unassociated with the infection in an adult should receive a biopsy". Such an admonition is neither new nor unique but is based upon sound clinical Nevertheless, patients not infrequently are seen in the clinic who have consulted capable doctors and the glandular hypertrophy either has been disregarded or attributed to a benign process In 2 of the patients whose histories are included in this report, the glandular adenopathy was noted by the physician or called to his attention by the patient, but the desirability of a biopsy was not pursued at that time It is believed by us to be sounder clinical medicine occasionally to remove a benign gland in practice when the policy is to biopsy any unexplained hypertropluc gland than to explain away readily glandular lymphadenopathy and biopsy only if the patient is acutely ill or the disease is far advanced Early recognition of Hodgkin's disease will be posssible only if a liberal attitude Furthermore, a clinical diagnosis of Hodgkin's disease should not be made without a biopsy The cervical or axillary glands are to be preferred to the inguinal nodes radiation may alter the pathologic appearance of lymph nodes, radiation therapy should be withheld in most instances until after the biopsy has been affected

Hypertrophy of hilar or mediastinal glands by x-ray also may be of diagnostic help. Four of the 6 patients in this series had positive findings by x-ray at some time in the course of the disease. In most instances the changes were observed at the first admission in the absence of physical signs in the chest. Only one patient had symptoms which suggested mediastinal involvement. Thus we believe that any patient suspected of having Hodgkin's disease and any patient with unexplained. lymphadenopathy should have an x-ray examination of the chest.

The enlargement of the spleen is present in a majority of patients, enlargement of the liver in a smaller number. Examination of the peripheral blood is of little diagnostic help. Frequently, an anemia is observed as well as a polymorphonuclear leukocytosis with a shift to the left but obviously these findings are not diagnostic. Bone marrow aspiration usually is of no greater aid than examination of the peripheral blood except in patients with marrow infiltration.

The skin is involved in more than a third of the patients and skin symptoms, particularly pruntus, are present in a larger number. Mycosis fungoides, at times a precursor of Hodgkin's

disease, is of considerable diagnostic help. Ur ticina dermatitis, and macular papular makes are more common. Rarely is the skin the site of granulomatous deposits.

Constitutional symptoms vary greatly in their everity and time of appearance Not in frequently patients with Hodgkun's disease may have few complaints. Others may note weak ness, malaise, loss of weight, or fever. An intermittent type of fever, identified as Pel Ebstein in type is not regularly present but should be watched for in any suspected case.

# Treatment with Nitrogen Mustard

Two of the patients in this small group were treated with nitrogen mustard Several additional patients either with Hodgkin's disease or suffering from other maladies were also treated with this preparation during the past eight months. The results obtained are similar to those reported by others 7 in much larger series for longer periods of time H C was given one course of nitrogen mustard when he was acutely ill with a profound anomia. Clinical benefit followed and persisted for approximately two The drug did not appear to affect the hemotopoetic system unfavorably as judged by laboratory studies or clinical symptoms Following the short period of clinical improvement the patient relapsed and radiation therapy was It was concluded that definite but short-lived benefit resulted from mitrogen mustard while the generalized infiltration of granulomatous tissue was affected to a minimal extent

The second patient M S was given introgen mustard to ascertain whether it would have any demonstrable effect upon Kaposi s skin sarconn No change was observed in the skin lesions following one course and further treatment was not considered indicated. This patient had a nilld form of Hodgkin's disease and significant regression of the superficial glands was not noted

Eight additional patients with proved Hodg kin a disease have been given nitrogen mustard in this hospital recently Two have died and little or no effect upon the ultimate course of the disease was evident Transient benefit has been observed in most of them. However in no patient with Hodgkin's disease was greater regression of glands or abdominal organs noted than is to be expected with x-ray therapy concluded that the results observed in this clinic are no more favorable than observed elsewhere. It is believed that the current policy should be conservative in regard to the use of nitrogen mustard in the treatment of Hodgkin's disease If the patient responds well to radiation, this is believed to be the treatment of choice. Most climes have had wide experience with radiation and the beneficial effects as well as the limitations of this procedure are well known. Nitrogen mustard on the other hand is a new drug and demands continued and extensive trial before adequate evaluation of it will be possible. It appears to be an adjuvant in selected cases, in others it may replace radiation when the patient becomes so-called radiation resistant.

The use of nitrogen mustard in other conditions in this clinic has been very limited. patient with multiple myeloma appeared to receive no benefit. The patient died a short time later and at postmortem examination no pathologic findings attributed to this new drug were observed. One patient recently admitted for lymphosarcoma was given the drug with no greater effect upon the glands than would be anticipated from radiation A third patient with mycosis fungoides has had two courses of nitrogen mustard with improvement of skin lesions following each course. Its use in polycythemia vera is looked upon with skepticism in this Spray radiation with or without an occasional venesection is considered to be an effective form of treatment of this malady hence our preference for those relatively safe procedures in comparison with the use of a highly toxic substance

#### Summary

An abstract of each of 6 patients with Hodykin's disease has been presented In addition to the frequent occurrence of the accepted criteria of this malady, i.e. generalized lymphadenopathy hilar and mediastinal hypertrophy by x-ray examination, cutaneous manifestations fever, weakness, malaise and weight loss, each of the patients presented one or more unusual features The first patient had a mild form of the disease incidental to chronic valvular heart disease The second patient had Kapon s skin sarcoma prior to the detection of adenopathy The third patient had severe secondary anemia and at postmortem examination had extensive bone marrow infiltration. The fourth patient had pruntus and other akin symptoms before adenopathy The fifth patient had what appeared to be primary liver and spleen disease while the sixth patient had a high circulating eosinoplulia

Each of the patients was treated with rada tion. Two of the patients had one course of introgen mustard in addition. Other patients with Hodgkin's disease and patients with other diseases have been given nitrogen mustard also in recent months. No greater benefit has been observed following the use of nitrogen mustard in this hospital than has been observed in a larger series of patients in other clinics and no greater effects were observed in this hospital than have been observed in patients receiving radiation

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# CIRRHOSIS OF LIVER NOT SYNONYMOUS WITH ALCOHOLISM

A serious disorder of the liver, known as cirrhosis. has been persistently identified as alcoholic in origin Three Philadelphia doctors suggest in the interest of scientific accuracy "that all reference to any type of cirrhosis as 'alcoholic cirrhosis' be abandoned.

Despite the progress of medical science in recent years in the study of the origin of cirrhosis of the liver, "its cause and mode of development continue to remain part of the mysteries of medicine," according to Drs Russell S Boles, Robert S Crew, and William Dunbar, from the Medical and Pathological Departments of the Philadelphia General Hospital, writing in the June 21 issue of the Journal of the American Medical Association

Portal cirrhosis, the type most frequently found in this country, is generally accepted as being synonymous with alcoholic cirrhosis, state the authors In the portal area is a branch of the portal vein which drains the blood from the intestinal tract the portal vein becomes obstructed by degenerate cells which are replaced by scar tissue, increased pressure is necessary for forcing blood through the liver

This leads to disastrous conditions such as profuse bleeding, jaundice, and swelling of the abdomen and later the legs

The authors present an analysis of 3,637 postmortem examinations made between 1942 and 1946 In this group, 142 cases of portal cirrhosis were It was possible to obtain an accurate history concerning the use of alcohol in 64 of the 142 cases Fifty were alcoholics and 14 claimed total abstinence In the remaining 78 cases there was either no record of indulgence in alcohol, or the his-

tory concerning its use was questionable
"It is significant that in younger persons with cirrhosis, namely those under 40 years of age, nine of 13 admitted heavy drinking," the authors point out Alcoholism is thought to contribute to the produc-

tion of cirrhosis of the liver because it is believed that the alcoholic never eats enough and therefore does not get the essential substances, or if he does take food he does not digest and absorb the needed factors

On the other hand, the authors cite the theories of other investigators who believe that cirrhosis of the liver may be caused by intestinal bacteria following intestinal irritation from alcohol, acid fermentation or some other agent, allergic reaction resulting in shock, the result of repeated injection of egg white or other protein and bacterial infections combined with poisons that are toxic to the liver

# NEW DIRECTOR OF RED CROSS BLOOD PROGRAM

Vice Admiral Ross T McIntire, wartime surgeon general of the US Navy and formerly White House physician, has been named director of the new National Blood Program of the American Red Cross

Recently approved as a Red Cross activity by its Board of Governors, the long-range program contemplates the provision of blood and its derivatives,

without charge for the products, to the entire Nation

President O'Connor explained that Dr Foard McGinnes, operating vice-chairman of Services of the American Red Cross, who has been instrumental in the origin and development of the project, will continue to have over-all responsibilities for the organization's medical services

# ICE BREAKER

A young woman doctor in my husband's office was eager to ingratiate herself with her colleagues One morning she came across a reprint on a pet subject of one of her male confreres In a fever to please, she phoned to say she was sending him an article that was right up his alley

Next morning the article came back with a note saying, "I didn't know you cared!"

She had sent him, not the intended material, but another reprint, entitled "Use of Androgen in Cases of Impotence "-Medical Economics, June, 1947

### OFFICE MANAGEMENT OF THE NEURODERMATOSES

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THE concept of psychic factors in association with certain diseases of the skin is generally accepted. In a few syndromes such as dermatus factuta the psychogenic origin is self evident. In some cutaneous disorders the only disturbance in the central nervous system is a consecutive one due to associated pruntus disability, or disfigurement. The role of the psychic as a major or minor causative factor in other skin diseases, loosely grouped as the neurodermatoses, is subject to considerable discussion by dermatologists. It is our belief that psychic trauma or conflict are important etiologic factors in the production of this latter group of diseases

Notwithstanding the increase in knowledge of the internal forms of psychosomatic disease little progress has been made in the interpretation and management of the cutaneous manifestations. The lack of progress may be considered due to several reasons, of which the following seem important

or milit

1 The traditional symptomatic approach

2 The heavy office schedule of many derma tologists who are apt consequently to overstress the some and minimize the psyche

3 Lack of understanding of the various types of the neurodermatoses

4 Lack of comprehension of the principles and technics of investigation

5 Misleading information in some current texts and articles

In this paper, information regarding the mechanisms in the production of derinatoses will be presented, for unless the basic mechanisms are correctly interpreted, the rate of cure will be low and the percentage of relapse high. A method of approach which has proved of value in over 100 patients will then be submitted and some of the difficulties encountered and successes achieved will be summarized

# Classification of the Neurodermatoses

- A. Dermatoses always psychic in origin
  - 1 Dermatitis factitia (artefacta)
  - 2 Neurotic exconntions
  - 3 Trichotillomania
  - 4 Acarophobia
- B Dermatoses always psychogenic but often with additional etiologic factors as well
- Presented at the 141st Annu I Meeting of the Medical Society of the State of New York Section on Dermatology and Syphilology Thursd y May 8 194

- 1 Lachen simplex chronicus (localized neu rodermatitis)
- 2 Acute neuroxlermatitis
- C Dermatoses frequently but not always psychogenic in origin
  - 1 Pruntus
  - 2 Alopecia arenta
  - 3 Urticana
  - 4 Hyperludrosis
  - 5 Vesiculo-bullous dyshidrosis of hands and/or feet
  - 3 Glossodynia (burning tongue)
- D Dermatoses combining psychogenic and other etiologic factors
  - 1 Atopic dermatitis (disseminated neurodermatitis)
  - 2 Rosarea
  - Synergism with sensitization dermatoses
    - (a) Activation of latent dermatophytid
       (b) Contact dermatitis
    - (c) Dermatitis medicamentosa
- C Dermatoses which may be aggravated by psychogenic factors
  - Seborrheic dermatitis
  - 2. Paoriasia
  - 3 Pitymasis rosea
  - 4 Miscellaneous

# Symbolism

Symbolism of lesions has been given emphasis in recent years by Weiss and English and others. For these investigators the character of the lesions and their location in the body are thought to have a special meaning. For example, Weiss and English consider that neurotic vomiting is an unconscious effort on the part of a patient to reheve himself of a disagreeable situation Simi larly hysterical blindness is the attempt to shut out unwanted sights MacKenna2 and others have suggested that the neurodermatitides may have a corresponding symbolic meaning cally, MacKenna refers to dyshidrosis of the feet and hands in a combat soldier as an unconscious rebellion against marching and firing a rifle Accordingly a comparative tabulation was made of the type and location of dermatoses and the underlying conflict in a series of over 200 patients with psychosomatic dermatoses. On the baus of these studies the following interpretation of data is submitted

A. As expressed by the type of lesion

 Pruritus (variably present in most psychosomatic dermatoses)

- (a) Localized and recurrent lichen simples chronicus, longstanding worry and anxiety with makeshift adjustments
- (b) Pruritus plus neurotic excoriations resentment against environment
- (c) Recurrent episodes of orginatic character sexual maladiustment
- 2 Paresthesias (acarophobia, glossodynia) phobias, usually of disease
- 3 Neurotic excornations (frequent accompaniment of pruntus) anxiety, desire for sympathy and attention, attempt to remove unsightly lesions from skin (i.e., acne), hostility reaction, at times in psychotic states
- 4 Dermatitis factitia (self-induced eruption)
  - (a) Severe maladjustment, often in hysterical types
  - (b) Antisocial and destructive tendencies,
  - (c) Narcissism and other forms of psychopathic personalities
- 5 Acute exudative neurodermatitis of flush areas severe anxiety, acute or prolonged unsolvable conflicts
- 6 Atopic dermatitis (disseminated neurodermatitis) prolonged social resentment, hostility, compensatory aggression
- 7 Urticaria acute phobias with anxiety, hostility, and anger
- 8 Rosacea inferiority and self-consciousness, prolonged social anxiety
- 9 Hyperhidrosis insecurity or fear, prolonged social anxiety
- B As expressed by localization of lesions
- 1 Scalp (alopecia areata) inadequacy, acute shock with insecurity
- 2 Head (rosacea, seborrheic dermatitis, eczematous ear) social anxiety, stigmatization, guilt
- 3 Blush areas (acute neurodermatitis, rosacea) guilt, social anxiety
- 4 Hands and feet (pompholyx) dislike or fear of occupational duties
- 5 Penis or vulva (pruritus, lichenification, eczematoid dermatitis) sexual disturbances
- 6 Scrotum (lichenified eczema) domestic and sexual conflicts, maladjustments or frustrations in these spheres
- 7 Anus (pruritus, lichemification) sexual or domestic conflicts, severe anxiety in "anal" types, homosexual tendency in men
- 8 Generalized severe anxiety or maladjustment involving entire environment

# A Method of Psychosomatic Investigation

The psychosomatic investigation utilizes both objective findings and anamnestic data for the interpretation of underlying causative mechanisms. Valuable information may be obtained by careful study of the eruption as mentioned under symbolism. The line of questioning then may be somewhat predetermined and valuable time saved. As a background for the development of the eruption, the adjustment of the individual in his progress through life is first considered. The

behavior pattern of the individual and the salient personality features then are compiled over, previous studies have shown that the type of dermatologic reaction is dependent not only on the specific behavior patterns but, also, on the nature of the precipitating episode From this information, the probable reaction of the individual to various situations and specific conflicts It is important to determine may be adduced the life setting of the individual just prior to the onset of the present illness Finally, the onset, development, and progression of the present illness should be correlated with specific precipitating incidents in both the somatic and psychic realms

# Outline

- 1 Initial Summary of objective features of dermatosis
- 2 Preliminary Investigation (if indicated) to rule out other causative factors
  - 3 Family History
  - (a) Parents personality types, general adjustments, marital history, strictness emotional relationship of patient with parents Physical diseases, age at death, and age of patient at death of parent
  - (b) Siblings number, sex, chronologic position of patient, physical diseases
  - (c) Nervous breakdowns, etc
  - 4 Health Record
  - (a) Diseases, general physical status, injuries, reaction of patient to diseases Pseudohereditary tendencies (symptoms, etc., similar to those of parent)
  - (b) Addictions tobacco, alcohol, need for drugs
  - (c) Dreams type and frequency
  - (d) Neurotic traits nail-biting, thumbsucking, bedwetting, tantrums, lying, or stealing, late fears, compulsions, or tensions
- 5 General Adjustment Chronologic story of life, taken up under several headings, as follows
  - (a) Family life childhood, adolescence, and adult life, with relationship to parents and siblings
  - Education details of, interest in, progress, relation to teachers and schoolmates
  - (c) Social life adaptability, friends, hobbies religion
  - (d) Work record details, interest, and progress, stability, income
  - (e) Sexual life development, adult pattern, necessity, normality (escape mechanism?) Details of marital life including engagements, marriage, and divorce
  - 6 Behavior Pattern
  - (a) Dominating or submissive
  - (b) Goals in life

- (c) Emotional trends cheerful depressed, unstable, etc.
- (d) Introversion or extratension (motivating stimuli from within or without)
- (e) Constricted or dilated personality
- (f) Reaction to authority thinking talking out troubles, substitute activities active aggression
- (g) Personality type compulsive anxiety, hysteria neurasthenia, psychopathic
- Preparation for Illness

Correlation of prolonged conflicts, life situation prior to onset, with type of individual in his life setting

- 8 History of Present Illness
- (a) Chronologic correlation of stresses, strains traumatic events, and subsequent conflicts with appearance and progression of present condition
- (b) Purpose served by symptoms
  - Symptoms as an expression of and defense against conflict
  - 2 The idea of compensation, escape from unpleasant duty
  - 3 Centering of attention on inadequate
- (c) Reactions to present illness enjoyment, fear, rain, and discomfort
- (d) Amount of associated neuromuscular tension dreams
- (e) Insight into present condition, will to

### Clinical Data

The clinical study of patients as outlined above has been carried out with both office and dispensary patients. In this communication a summary is submitted of the case records of 36 patients studied in private practice. Several illustrative case reports will be given in detail This series represents the more difficult psychosomatic problems encountered in one year of office practice during which time approximately 1 000 new patients were seen. The patients ranged in ages between eight and fifty nine the average age at onset of the disorder being forty-There were 19 women and 17 men. In general it was noted that private patients were more difficult to manage and had a higher per centage of compulsion types of personality as compared with the more amenable anxiety type commonly seen in clinic patients.

Furthermore aggressiveness, self-esteem and egoism were more prominent traits with more resistance to adjustments of fundamental conflicts. These patients had greater will power and consequently were able to submerge their conflicts to a subconscious level, which in turn

resulted in increased resistance to therapy Finally, they seemed to exhibit a more diverse fied type of reaction with frequently two or three different psychosomatic manifestations. It is of interest that lichen Vidal, neurotic excorations. and rosacea, common manifestations of anxiety, were more common in clinic patients, whereas pruritus ani, dyshidrosis and "neurogenous cars," in which multiple factors are frequent. were seen more often in private practice. In the early life of most of the patients problems in adjustment and personality development were prominent. Consequently, personality disorders were common and the patients as a group were unable to cope with specific conflicts which occurred in adult life Excessive aggressiveness and a frequently strict religious background combined to produce more conflicts in the sexual sphere than were present in the chine group

Of the 36 patients the cutaneous reaction types are listed in Table 1—It is of interest that multiple manifestations were present in 30 per cent of the patients fifty individual dermatologic complaints occurring in the entire group

TABLE 1-DISTRIBUTION AND FREQUENCY OF DERNATORES

IN 30 PATIENTS				
Reaction Type	Frequency			
Pruritus ani	11			
Lichen Vidal	5			
Urticaria	5			
Neurogenous ears	4			
Dyshidrosis	4			
Venrotic excoriati ne	3			
Pruritus vulvae	3 2			
Scattered pruritue	3			
Ecsematold dermatitle	3			
Al pecia areata	3			
Seborrheio dermatitio	2			
Trichotillomania	1			
Acute neurodematitis	1			
Rosacea	1			
Dermatitla factitla	1			

In many instances it was difficult to determine the personality type and predominant emotional reactions of the patient since anxiety and tension states frequently coexisted to varying degrees, depending on the individual attuation Definite compulsive-obsessional tendencies were noted in 11 instances, while anxiety to some degree was present in 18 patients. Depression combined with neurasthenia was determined in 4 patients A history of childhood maladjustments was obtained in two thirds of the patients A history of psychic trauma as a precipitating factor was absent in 17 patients Physical and endocrine precipitating factors occurred in 8 individuals Precipitating factors of any type were not discovered in 11 of the patients.

On the other hand fundamental maladjustments and multiple conflicts were active over many months or years in all but 3 patients in two of these psychosomatic investigation was incomplete because of poor cooperation. In general, the maladjustments and conflicts were of a diverse nature Specific sexual conflicts were present in only 25 per cent

# Getting the Patient Well

From the foregoing, it is evident that the problems presented by these patients are individual and that prolonged, painstaking therapy As would be expected, it was found is required that the best results were obtained when therapy included both physical and psychic measures The purely symptomatic approach, eg, \radiation for lichen Vidal or pruritus ani, while of undoubted value in the amelioration of symptoms, did not correct the underlying problems In these instances the almost inevitable result was a subsequent relapse, the development of a related or different type of neurodermatosis, or psychosomatic complaints involving other body structures Accordingly, treatment of physical and endocrine abnormalities was accomplished in conjunction with measures designed to correct the underlying maladjustments and conflicts It was possible frequently, over a period of weeks, not only to obtain the confidence and cooperation of the patient, but also to make helpful suggestions toward the solutions of the individual difficulties

The following case histories are cited as illustrative of some of the problems encountered and the results achieved

# Report of Cases

Case 1—R P, a Jewish-American fur-broker, aged 43, had been bothered with pruritus ani for four years. A preliminary history and appraisal did not reveal any obvious physical or constitutional diseases, but a nervous breakdown, six years previously and subsequent prolonged psychotherapy suggested the need for a psychosomatic investigation

The early family life was unsatisfactory, the parents getting along poorly tog ther, consequently, the home atmosphere was one of tension, insecurity, and distrust. This led to the development of pay-

choneurosis in two siblings

The health record included a severe asthma, beginning ten years previously and ostensibly due to fur allergy. This disease was pseudohereditary, the mother having had asthma for many years. Eliminations of allergens and injection therapy were valueless, the asthma finally involuting as a result of prolonged psychotherapy while he was in continued contact with furs. Indefinite gastrointestinal complaints accompanied the first nervous breakdown. The patient was an inveterate smoker. Early neurotic traits were not clinically manifested, but fears, compulsions, and tensions became evident during and after adolescence.

His general adjustment through life was beset with many difficulties. Always a sensitive, introspective child, he was forced to witness, between the

ages of three to four, his parents in the act of sexual intercourse He was terrified by these experiences. feeling that his father was overbearing and cruel to his mother, to whom he was closely attached Hatred and fear of his father and of his big penis. and excessive dependence on his mother soon resulted in insecurity and inadequacy, which has since influenced his school, social, sexual, and work life As a result of this, he acquired three college degrees and developed an outward harshness and overbearing demeanor Because of an excessive mother attachment his early experiences with women were in frequent and casual He finally married at thirtysix, but the latent homosexual trends have continued Throughout his life, until recently, tension and anxiety were relieved by masturbation, in occasional heterosexual experiences he was relatively ımpotent This impotence (imagined lack of masculinity) continued on into his marital life until finally cured by psychotherapy — In the work sphere he felt insecure and inferior to his fellowmen, as a consequence he suffered the "tortures of the damned" in his business relationships, especially in conferences or important business dealings

The behavior pattern revealed a compulsive type of individual, with marked anxiety and instability Compensatory domination and introversion were present, he was relatively constricted. His reaction to authority (man) was either by thinking out troubles or by active aggression, depending upon the state of his ego at the moment and the type of man with whom he had to deal

The preparation for illness was in the period following a second nervous breakdown, and, at the time, he was gradually recovering from his more deep-scated difficulties (acute psychoneurosis, asthma, impotence) as a result of psychotherapy The pruritus ani, then, may be regarded as a superficial somatic defense against the residuum of his deep-seated conflicts and, as such, a way-station on the road to cure It is significant, also, in its symbolism of his predominant maladjustments pruritus was expressive of anxiety The location symbolized his latent homosexual tendencies, and its character was clearly of a masturbating type, indicating a residual need for immature autosexual ac tivity to relieve business tension and insecurity, and to express his latent distaste for heterosexual expression

The patient was seen over a period of eight months, first at weekly and then at more infrequent intervals. X-ray treatment was administered, concurrently, the nature of the new development was gradually revealed to him, and continued encouragement and practical suggestions given. After some twenty visits the pruritus had practically disappeared, he faced life with relative equanimity and continued to make an increasingly better adjustment to his problems.

Case 2—T P, aged 36, a laundry-operator of Maltese extraction, had been bothered with severe urticaria for two weeks—Inquiry regarding drugs, allergic contacts, and foci of infection yielded negative results—The past history was not completely evaluated but the patient was of a compulsive-

obsessional type chromically overworking for many years. In the past two months excessive business wormes developed. One week prior to the onset of the urtlearia, he became the intended victim of an underhanded business deal which if successful might have had disastrous consequences. He became greatly incensed at this development and twas in this setting that the urtlearia developed

Benadryl therapy was administered and tho mech anism underlying the production of the lesions out lined to patient Cure was rapid and uneventful

Case 3 -D E a housewife aged 50 was raised in an irresponsible and somewhat neurotic family Consequently she had to assume extra responsibilities at an early age partially supporting three indolent brothers and an alcoholic father Because of these circumstances a long-cherished wish for an advanced education was denied her She became happily married at 26 and got along well until she was forty four at which time her husband went into bankruptey and the patient again was shouldered with heavy responsibilities. During this period a large patch of lichen Vidal developed on the kit knee and upper leg, with final involution three veurs later with improvement of business. How ever she continued to work to help out the family finances During the following year she was transferred to a new position which entailing as it did the shouldering of responsibilities of others in social work, was distasteful to her At this time circum scribed lichen Vidal began on both palms and on ankles She continued the same work until recently and during this entire time was plagued with the itching dermatosis. More recently it has been aggravated by the impending breakup of her daughter a marriage and her return home (more responsibilities)

The cruption was temporarily improved five years previously by a long series of x-ray treatments Endocrine antiprinrite and soothing remedies were prescribed at this office, with considerable temporary improvement. She has been persuaded to give up work and live at home measures to lessen her responsibilities have been suggested. A permanent cure, however is hardly to be expected except with much closer supervision and cooperation than is likely to be obtained in this particular situation.

Case 4.—A B a marine sea captain aged 43 has had an intractable pruritic eczematoid dermatitis of both external cars for four years and an equally severe pruritus am for one year. He had an unfortunate childhood life his father being a psychopathic personality (vagrant) and his brother a chronic alcoholic Consequently he loved his mother and hated his father. He was a shy and retiring child because of physical disabilities as a result he has made but few friends and then only with difficulty He left school after the seventh grade and for twenty years drifted from one job to another mostly in a laboring capacity. In the past five years his past experience as a merchant seaman allowed lum to rise rather rapidly to his present station

His personal and sexual life have not been satisfactory. Physically health, he has been subject to many injuries and at least five serious fractures.

(fracture personality of Dunbar) Sexual experiences to lum have always been a method of working off tension and an excape from the daily banality and frustrations of life. He has been intimate with at least twenty five women and has had four mistresses since his marriage seven and a half years ago. His wife is a heavy drinker and is abnormal in that she does not wish to have children. She has already had two induced abortions. These traits led to considerable domestic conflict.

During the past few years the patient has tended to setth down and has assumed more and more of the responsibilities of adult life. It was during this period of his transition to a more stable, conventional type of life and while he was on a visit to his wife that the neurogenous cars developed. As such evidence of a definite guilt complex could be determined. The pruritus aim on the other hand doveloped during a period of sexual abstinence, while at sea and it is of interest that a masturbation pattern could be identified.

The patient was seen over a number of weeks radiation was administered and some attempt was made to explain the underlying mechanisms involved. However he left for another city before therapy could be completed and a recent letter from a colleague states that the complaints are still present with undiminished intensity. Clearly prolonged revelotherapy is needed in this case

Case 5 - J S a 52-year-old clerk, had had pruntus and neurotic excoriations of the face for some fifteen years The eruption was complicated by secondary pustular folliculitis on a number of occasions and by a severe attack of edematous and plaque dermatitis from penicillin The patient was of Scotch Irish origin, and was brought up in a lower middle class environment and in a rather closely knit family He was closely attached to his mother and depended to a considerable degree on her did moderately well in school but was not particularly ambitious leaving college to take a job in a brokerage house He had occasional sexual experiences with women beginning at the age of twenty but it is significant that he never became seriously interested in the opposite sex until shortly before the death of his mother when he was thirty-seven He marned the following year and made a satisfactors social and sexual adjustment to marital life

However his financial status has remained in a precarious state throughout his married life. He has held a minor administrative job with just sufficient funds on which to live, until his wife con tracted a severe illness four years ago with a partial residual incapacity to date. Since her illness he has incurred substantial debts and his had a difficult time maintaining a home for his young son. During this four year period it has been necessary for his wife to spend months at a time with her parents, so that special care could be given. He lived alone during much of this period.

The pruritus and excenations were first noted shortly after the death of his mother at which time he was first compelled to assume the normal responsibilities of manhood. The trouble continued for the most part in mild form through the years

It is noteworthy, and possibly related to his longstanding mother-fixation, that the condition was not aggravated during the acute serious phase of his wife's illness Six months ago, and for the first time in years, an opportunity arose for him to better himself with a position which combined a significant increase in salary with corresponding increase in re-During this period of uncertainty sponsibility while the applicants were being considered, he exconated his face so severely that he was automatically eliminated as a possible candidate for the Secondary infection and reactivity to penicillin then supervened and investigation and treatment were initiated

1894

He was followed over a period of some three months. Initially he was convinced that his complaints were solely physical in nature, but as time went on the relationship between the longstanding anxiety-state and the development of the lesions became increasingly evident to the patient. Involution was nearly complete and a more satisfactory adjustment to the conditions of his life had been obtained at the time of his last visit.

Case 6—H F, aged 44, developed severe bald areas in his scalp and bearded region during the past six months

The family and early life history were negative. the only significant finding being that the mother was a nervous, excitable type The patient was a self-made man He began work after completion of high school, starting in a minor capacity but gradually advancing himself, by dint of continued application and conscientiousness, to positions of increasing responsibility One and one-half years ago his steady advance was temporarily sidetracked by a position which made great demands on his time but which offered little chance of advancement opportunity, which he felt eminently qualified to fill, became available about a year ago However, due to favoritism and company politics he was bypassed by one of his own subordinates

Since that time he has developed a definite sense of inferiority with regard to his position and in his relationship to his fellow employees. He has found it difficult to face his friends and became so agitated and anxious that he developed insomnia and found it impossible to relax. Just prior to the onset of the present trouble he managed to control his active resentment and "put the whole business out of his

mind" It was at this time that the alopecia was first noted, as such, its development may be construed as a somatic substitute for the free-floating anxiety and resentment which formerly were present. The continued development of new lesions until the time of his first visit to the office may be explained on a similar basis.

The patient is still under observation but no new area of alopecia has developed and some regrowth has already occurred. The nature of his problem has been explained to him and to date he has made a very satisfactory readjustment.

# Summary

An office technic for the management of the neurodermatoses is outlined This embraces a preliminary appraisal of the patient to exclude primarily physical diseases or to evaluate their relative importance in the causation of the presenting disease A special investigation is then documented and the details are exempli-It should be fied by illustrative case reports emphasized that these procedures, while not as time-consuming as psychoanalysis and related technics, cannot be effective with brief con-With the combined psychosomatic and symptomatic methods of therapy, the results of treatment were decidedly good, 50 per cent of the group being cured or markedly improved, while 22 per cent were slightly or not improved The remaining 28 per cent lapsed from observation, of these, 14 per cent may be considered as complete failures, while the other 14 per cent were seen only in consultation or have moved from the neighborhood

While the management of the neurodermatoses is still difficult and the results uncertain in many instances, it is hoped that the methods of interpretation and therapy advocated in this paper will be of practical value to the dermatologist

66 East 66th Street

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# MEDICAL PUBLICATIONS NEEDED OVERSEAS

As a result of war and persecution, doctors, dentists, and technicians in allied fields throughout Europe have been deprived for more than ten years of news of the latest developments in their professions—the kind of news and analysis contained in this JOURNAL

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### MYOCARDITIS IN MALIGNANT TERTIAN MALARIA

IRVING GREENFIELD, M.D. FACP Woodmere, New York

ACUTE MI OCARDITIS occurring during the course of Plasmodium falciparum malaria was sufficiently unusual to warrant the following case report

A 22 year-old marine was admitted to the Eighteenth Station Hospital in November 1943 dur ing his fourth attack of malana. P falciparum was identified on examination of the blood amear. He responded well to the routine atabrine regimen Because of the fact that a regularly recurring pulse irregularity noted on admission persisted after clini cal improvement in his malaria had occurred he was sent to another hospital where facilities for more

complete study were available.

Physical Examination - His height was 70 inches weight 155 pounds pulse 60 and the blood pressure weight 155 pounds place of and the hood pressure was 120/80. The patient was an asthenic normally developed white man The heart was not en larged. \( \) shocks or thrills could be palpated over the precordium. Premature beats recurring regularly following each fourth normal heart beat were palpated at the apex. Each premature beat was followed by a compensatory pause heart sounds were of fair muscular quality The aortic and pulmonic second sounds were normal. A soft short, crescende type of systolic murmur was audible at the apex. It was sharply localized and was present in all positions as well as following exercise. Although the cardine rate was markedly accelerated following exercise the quintigeminal rhythm persisted. The remainder of the examina tion was normal.

There were no abnormalities of the cardiac ailhouette An electrocardiogram taken on December 15 1043 revealed that the PR interval was 0 32 Premature ventricular contractions of second. right ventricular origin occurred regularly following each group of four normal complexes. The reeach group of four normal complexes. The mainder of the electrocardiogram was normal. diagnosis of first-stage heart block and of quniti-

geminal rhythm was made.

The past history revealed recurrent sore throats and uncomplicated scarlet fever in childhood After the age of ten, however his health was unusually good In December 1942 in February, 1943 and again in April, 1943 he had clinical malaria. In October 1943 he had a sore throat, it lasted a few days and was so mild that he did not report on sick call During the course of the third attack of malaria, which occurred in April, 1943 he was aware of the fact that his heart turned over occasionally There is no mention made in any of the previous hospital records that a cardiac ar rythmia was noted At first these peculiar sensations' occurred infrequently Later on, they recurred up to several times daily Occasionally they were accompanied by light-headedness." spite of these facts he never reported them on sick

The patient remained afebrile following the

Norz: The author wishes to express his thanks to Lt. Co. Leo Peterson, M.C., for his succurragement. Photographic reproductions of the selectrocardiographic thanks admissed would have been desirable. However under combat conditions, this was not possible.

course of atabrine His only complaint was that he was aware of an extra heart beat. An electrocardiogram taken seven weeks after the first one reported above revealed that the PR interval was 0.28 second The quintigeminal rhythm remained With continued bed rest because of unchanged case of fatigue, the patient continued to improve After ten weeks the PR interval returned to within normal limits of 0 18 second There was no change in the quintigeminal rhythm. At this point, the patient was evacuated from the tropics.

#### Discussion

In the absence of autopsy investigation one must speculate concerning the nature of the pathologic process which was responsible for the above-noted clinical observations. With this in mind, it is of interest to consider the role which the malaria para

site played.

Malaria is a disease which is characterized by recurring attacks of fever If untreated, there is deposition of a black pigment in the organs of the Brown<sup>2</sup> suggested that this malaria nig ment acts as a hemolysin which by its destructive action on endothelial cells may be responsible for capillary hemorrhage A second pigment hemosid erin also may be seen in the lumina of capillaries either partially or completely occluding them. In intense infections it is not uncommon to find the lumina of capillaries occluded with thrombi made up of pigment red cells phagocytic cells cellular debris and free parasites,\*

Auriculoventricular block is the term employed to designate interference with the passage of an impulse from the auricle to the ventricle. Injury to the cardiac musculature may be responsible for a prolongation of the conduction time. The injury may be mechanical, chemical, or toxic. Thrombi such as those mentioned above are not uncommon in sections of the endocardium as well as of the myocardium of individuals who succumb to infection with malignant tertian malaria.

The only other agent which might possibly be suspected is the atabrine which the patient took as a suppressive as well as a therapeutic drug. The studies of Heimann and Shapiros have shown that atabrine affects the amplitude of the complex as well as of the T wave. It, therefore is reasonable

to dismiss that drug as an etiologic agent.

Premature vontricular extrasystoles are probably the most common of all of the cardiac arry thmias, Most often they pass unnoticed. Hyman called attention to the fact that their mechanism is still obscure. Ungeleider and Gubner concluded that their persistence increases their significance. On the basis that the premature ventricular extrasystoles permsted for at least six months as well as the fact that the quintigeminal rhythm did not alter following exercise, it is suggested that the arrythmia noted in the case herein reported resulted from an organic rather than from a functional disturbance.

Soc 41 1 (1942)

# Summary

A patient developed heart block and quintigeminal rhythm during the course of malignant tertian malaria. In the absence of any other known etiologic explanation, it is suggested that these conditions were the result of localization of the parasite and of its products in the vessels of the endocardium and of the myocardium

799 CENTRAL AVENUE

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# RESEARCH FELLOWSHIPS-THE AMERICAN COLLEGE OF PHYSICIANS

The American College of Physicians announces that a limited number of fellowships in medicine will be available from July 1, 1948, to June 30, 1949. These fellowships are designed to provide an opportunity for research training either in the basic medical sciences or in the application of these sciences to clinical investigation. They are for the benefit of physicians who are in the early stages of their preparation for a teaching and investigative career in internal medicine.

Assurance must be provided that the applicant

will be acceptable in the laboratory or clinic of his choice and that he will be provided with the facilities necessary for the proper pursuit of his work. The allowance will be from \$2,200 to \$3,000

The allowance will be from \$2,200 to \$3,000 Application forms will be supplied on request to the American College of Physicians, 4200 Pine Street, Philadelphia, 4, Pennsylvania, and must be submitted in duplicate not later than November 1, 1947

Announcement of the awards will be made as promptly as is possible

# ANNUAL MEETINGS OF THE DISTRICT BRANCHES-1947

Thursday, September 25, Seventh District Branch, Veterans Administration, Bath

Tuesday, September 30, Fifth District Branch, Utica

Wednesday, October 1, Eighth District Branch, Jamestown

Wednesday, October 15, Sixth District Branch, Norwich (Arrangements have been made for State Society Officers to stay at the Hotel Chenango, Norwich, after meeting of Sixth District Branch)

Thursday, October 16, Third District Branch, Liberty

Thursday, October 23, Fourth District Branch, Amsterdam

Wednesday, October 29, Second District Branch, Garden City, Long Island

Thursday, October 30, First District Branch, Kingsbridge Hospital, Brony

# ANNOUNCEMENT

The Faculty of Medicine of Columbia University in the City of New York announces a concentrated course in Manipulative Surgery to be given at the Columbia-Presbyterian Medical Center by Dr

James B Mennell of St Thomas Hospital, London, and Oxford University, Monday through Thursday, 9 A.M to 5 PM, September 8 to 11, 1947
The fee will be \$40

# House of Delegates

# Minutes of the Annual Meeting

May 5 to 7, 1947

[Continued from page 1818 August 15 issue]

[Sections 16-51 appear in this issue For Subject Index see Lugust 15 issue page 1~99]

Section 16 (Sec 66 67)

Supplementary Report of the Council-Part XII Miscellaneous

Nursing -The meeting of the Coordinating Council on Nursing Problems held on April 17, 1047 was devoted largely to consideration of the recruitment and training of practical nurses. It was pointed out that the distribution of the fourteen registered schools for practical nurses in New York State is not good-there is one such school in Rochester one in Albany, and the rest are in New Schools are needed in Lrie Onondaga Chenango and Queens Counties The schools for professional nurses are not filled and it was sug gested that some of these schools might profitably be changed to schools for practical nurse training

A motion was adopted
"That this Coordinating Council on Nursing Problems push a practical nurse recruitment and education program and recommend improvements as indicated

The need for male as well as female nurses was stressed.

The following resolution was adopted

'Whereas there is a widely recognized need for practical nurses in New York State be it

Resolved, that this Council request suggestions from the Medical Society of the State of New York the New York State Hespital Association the New York State Nurses Association the Practical Nurses of New York, Inc. and the New 1 orl State Committee of the National Association for Practical Nurse Education for a professional and practical nurse education program further

Resolved, that these groups be asked to make suggestions for a recruitment campaign

It was voted that the Practical Nurse Associa tion be invited to full voting membership in the Coordinating Council on Nursing Problems

Memorial.—Dr James Murray Flynn

Whereas our friend and colleague, James Murray Flynn, after years of loyal service to his beloved profession died on Saturday, December 14

WHEREAR his was a colorful career—roentgenologist soldier, leader in organized medicine ability in his chosen field of roentgenology was un challenged and his long years of service as chief of the x ray departments in various Rochester hospitals brought a feeling of great comfort and security to these institutions and to their patients whom he served and

WHEREAS, he served with distinction in his special field with Base Hospital No 10 during the entire period of the First World War and

Whereas in his passing, organized medicine loses a staunch worker loyal friend, and dis-tinguished leader He was President of the Medi cal Society of the State of New York in 1940. prior to that he had been President of the Medical society of the County of Monroe and also of the Rochester Academy of Medicine, indicating the high esteem in which he was held by his brother practitioners and

WHEREAS, his vigorous mannerisms so characteristic of him covered a sympathetic and under standing nature and over the years he became the friend and confidant of countless physicians and

Whereas he was a stalwart champion of the rights of the medical profession, jealous of its honor and exemplified its duties and responsibilities in his own daily conduct and

Whereas his religious real and devotion to his family were well known and he leaves an honored name to those who survive him therefore be it

Resolved that the membership of the Medical Society of the State of New York loses a distinguished servant in his passing, and mourns our loss and be it further

Resolved, that these resolutions be published in the New York State Journal of Medicine and

that a copy be sent to Mrs Flynn

Belated Bills.- A bill of \$54 00 for expenses in curred by a member of Dr A H Aaron a committee in attending meetings of the Subcommittee on Medi cal Expense Insurance of the Committee on Public Relations and Economics This bill was recently received more than thirty days after the date of incurring of expenses and more than the additional sixty days later which the Board of Trustees are permitted to allow under Chapter 9, section 1 of the Bylaws Therefore the bill is submitted to the House of Delegates for authorization of payment

Section 17 (See 105)

#### Supplementary Report of the President

Speaker Andresen The Chair will now recog nize Drs Curphey and Van Kleeck of Nassau, who

will bring Dr Bauer our President to the platform
The delegates arose and applauded as Drs
Theodory J Curphey and Louis A. Van Kleeck, of assau County escorted Dr Louis H Bauer to the platform

SPEAKER ANDRESEN Have you anything to add Mr President? to your report, Mr President?

I RESIDENT BAUER | Yes I have Mr Speaker

Mr Speaker and Members of the House before I give my supplementary report there are two announcements I would like to make. One is that it seems there was a dog show in this building yester day afternoon and a dance last evening which broke up at 2 00 a m Our office force was unable to start to prepare this room for our use until 2 00 a m this morning, and I understand that three of Mr Anderson's assistants, Mr Marshall, Mr Neilsen, and Mr Streit, put on their overalls and went to work themselves cleaning this place up, even removing whisky bottles from the telephone booths, so we could have our meeting here this morning. Therefore, if things were not quite in order when you arrived this morning vou will understand why. I think we owe a vote of thanks to those three gentlemen whose job of public relations hardly encompasses the matter of sweeping floors.

The other announcement I wish to make is that one of our most talked-of problems of the past year has been workmen's compensation. There has been, I think, a disposition on the part of some of our members to feel that the Workmen's Compensation Committee and the Workmen's Compensation Board had not been too energetic. I want to disillusion you on that, if you had such an idea. They worked very hard, and it has not been an easy task. If you read the newspapers this morning you will see that some of our problems have been solved. I understand that Dr. Dattelbaum will make a supplemental report on that this morning, giving you the details, so I will not take up any time in giving them to you now.

I had expected to appear before you at this meeting as your President-Elect and not as President The tragedy of Dr Hale's death catapulted me into the presidency without warning. As stated in my preliminary report, the Society has suffered grievous

losses during the past year

I feel, and I should like everyone to feel, that this is Dr Hale's meeting and not mine. We have tried to carry out that idea as far as possible. We have kept Dr Hale's name on the program, the Society stationery, and on the masthead of the JOURNAL On Wednesday evening the President's Medal will be given posthumously to Dr Hale and will be received by his son.

At this time I think it would only be fitting that we should rise in a moment of silent tribute to Dr

Hale

The members arose and stood with bowed heads in silent tribute to the memory of Dr Wilham

PRESIDENT BAUER This Society has suffered other grievous losses, which you all know about, and the House will have an opportunity to pay tribute to these men later when the memorials are presented

to the House

During the past year the medical profession of the country has been through a siege. The forces which would place medical care under a bureaucratic control succeeded in having public hearings on the Wagner-Murray-Dingell bill. Although these hearings were carefully staged to convince the public that there was a great demand for enactment of this bill, the hearings fizzled out and the Committee never nendered a report. Although up to the present no rew version of this bill has been introduced, there doubtless will be in the near future.

There have been introduced, however, two bills of interest, one the Fullbright-Taft bill and the other the Taft-Smith-Ball-Donnell bill These bills merit careful study The Fullbright-Taft bill calls for an Executive Department of Education, Health, and Security, with an Undersecretary in charge of each division The Undersecretary for Health must be a doctor of medicine While we approve of grouping all Federal Health activities in a single department, and approve of the head of that department being a

doctor of medicine, it seems probable that the Sccretary would come from the field of Social Security or possibly Education, and that Health would be the tail to the doc

The Taft-Smith-Ball-Donnell bill calls for the establishment of a National Health Agency outside of the Cabinet, with a doctor of medicine at its head This bill has been analyzed by the Planning Committee, whose report is in your hands. Hence, I will not take your time in discussing it, except to say that it offers a way of carrying out some of the ten points of the American Medical Association Program. While the bill requires some amendments, it is my belief that we can endorse the bill in principle

We must be forward-looking in our program We cannot wait for things to happen We must exercise leadership and guide the public Our voluntary plans of insurance, which are but one factor in an improved national health program, have progressed more rapidly the past year, but progress is still too

slow

Controversies between indemnity and service plans, and between nonprofit and commercial plans, must be eliminated. Whatever is best for the public must be our aim. The next few years will settle this matter once and for all, and our action must be

both progressive and aggressive

The bulk of the medical profession is not yet alerted to the importance of our planning. There is too much of a laissez-faire attitude on the part of a majority of the medical profession. We must arouse the interest of the individual physician and revitalize our county societies if we are to be successful County societies at present are too poorly attended Without the active support of the county societies, your state and national organizations are helpless. The most important thing this House of Delegates can do is for each delegation to take it upon themselves to make their county societies vital forces during the coming year.

Our State Society is constantly expanding its activities and doing a tremendous job for the public and the profession. To continue, it must have more funds or else it must become less active. I know of no active state organization whose dues are as low as ours. One state, for example, has annual dues of \$100. (Let me interpolate that the year they raised their dues to \$100 they had less people dropped for nonpayment of dues than in any previous years.) It is my considered opinion that our dues must be increased.

The loss of several active personalities the past year has caused me to give considerable thought to our official family. We must encourage younger men to take an active part and train them to take over the burdens which constantly are growing heavier. It is ten years since our present Council was established. At that time the Society was smaller by several thousand members. Since then, the House has added the Chairman of the Board of Trustees as a member of the Council, and last year added the Second Vice-President, the Assistant Sceretary, the Assistant Treasurer, and the Vice-Speaker. These were wise moves. They result in the Council's being of a size more in conformity with the size of the Society and yet not so large as to be unwieldy.

The Board of Trustees handles the finances of the Society, and its problems have steadily increased over the years. We have been most fortunate in that the Board has consisted of a long line of distinguished physicians and capable financial administrators. Probably the finances of no organiza-

tion have been better administered, nevertheless, in my opinion the size of the Board is too small considering the increasing number of financial problems it has to solve At one time during the past year there were but four members due to the death of one, and one of these four was away. That meant that two members could have decided a financial matter As a matter of fact, the decisions of the Board were unanimous and the vacancy was filled a month later It is not fair, however to the Board itself to place the responsibility of important financial decisions on so few nor is it sound ad We might not always be so fortunate ministration in the makeup of the Board hence it is my recom mendation that the membership of the Board be in creased to nine two to be elected each year for five years except every fifth year, when only one shall be elected. Since members of the Board are apt to be from among the older members of the Society as they should have experience as officers or as members of the Council before serving on the Board a slow but steady turnover seems advisable fore it is recommended that no member of the Board be permitted to serve more than two terms the system followed by the American Association in the election of its Board of Trustees and it has proved most satisfactory

The following amendments are therefore offered Article VI of the Constitution shall be amended to

read as follows

"The Board of Trustees shall consist of nine members elected by the House of Delegates in accord ance with the Bylaws The President the Secretary and the Treasurer shall sit with the Board of Trustees with voice but without vote '

Chapter III Section 3 of the Bylaws shall be amended to read as follows

"Two trustees shall be elected annually except every fifth year when but one shall be elected, each to serve for five years. In case of a vacancy a trustee shall be elected for the unerpired term, provided that at the session of the House of Delegates at which this amendment is adopted one rustee shall be elected for five years one for four years one for three years one for two years and one for one year, that at the next four annual sessions two shall be elected for five years. No trustee shall serve for more than two terms but a trustee elected to serve an unexpired term shall not be regarded as having served a term unless he has served three or more years.

These amendments of course cannot be acted on at this session and must lie over for a year before

they can be considered.

Once again, I wish to express to the House my appreciation of the great honor conferred on me a Year ago. I realize the tremendous responsibilities of the office which seem to grow greater year by year. I bespeak the cooperation and help of all the officers the Council, the Board of Trustees and every member of the House of Delegates. We have many problems beaetting us and we must all work together to solve them. I wish to assure you that I shall do my best to carry out the duties you have placed on my shoulders and prove myself worthy of your confidence.

SPEAKER ANDEREN Thank you, Mr President:
The President's Supplementary Report will be
referred to the appropriate reference committee and
the amendments which he proposed according to the
Constitution and Bylaws as he mentioned will lay

over and be taken up next year

Section 18 (See 15 126)

Second Supplementary Report of the Workmen's Compensation Committee—Part X

SPEAKER ANDRUSEN Under supplementary reports Dr Dattelbaum has a report from the Committee on Workmen's Compensation which he is

going to read in its entirety

DR MAURICE J DATTELBAUM Mr Speaker and Delegates because of the confidential nature of this report written by Miss Mary Donlon it was impossible to incorporate the contents in any report or even in a supplementary report for it was only to be released today Monday morning, May 5 1047 Thorefore in accordance with her request we could not release it prior to this time

Payment to 23 550 New York State doctors for treatment and care of disabled workers will be in creased annually over three million dollars as the result of increased medical fees in workmen s compensation cases just authorized by Miss Mary Don, Chairman of the State Workmen s Compensation Board Fees the doctors charge for office and home calls, as well as for hospital visits are raused in a partial revision of the workmen s compensation medical fee schedule which will become effective Jung 1, 1947

Statistical data of the insurance carriers indicate that approximately 60 per cent of all fees in work men a compensation cases paid to doctors author ized to render medical caro under the Workmen s Compensation Law in New York State, are paid for ordinary treatment given to compensation claimants in office and home calls and hospital visits

This is the first revision of those fees since 1938 Modical care is provided by employers and the lia billty for increased medical fees will fall on New York State employers and not on the disabled work

crs

For many years employers and carriers have been entitled to a discount of 5 per cent for payment of medical bills of \$15, or more when paid within thirty days after the bill was rendered. The State and County Medical Societies have opposed this discount and Miss Donlon announced that the discount would not be allowed on bills rendered on and after June 1 1947.

In making public the increase in medical fees Miss Donlon aise called attention to the importance of prompt filing of medical reports by physicians Because tardiness in complying with statutory filing requirement is a frequent and serious cause of delay and resulting hardship for compensation claimants Miss Donlon said, it seems wise to amend the rules to inform physicians specifically of the reporting requirements in workmen's compensation crases. By law severe penalties apply to physicians neglecting their obligation to file timely and full reports mamely revocation of authorization to treat work men's compensation claimants and inability to enforce payment of their medical bills

Proposals for increase in medical fees have been examined by a committee representative of all groups concerned in workmen's compensation in cluding employers carriers labor and organized medicine with Dr. Nathan B. Van Etten of New York City member of the State Industrial Council as Chairman. The fee increases that become effective June 1 1947 were recommended by this committee which also recommended elimination of the 5 per cent discount on medical bills. The committee is continuing its study and will make recommittee to continuing its study and will make recommittee.

mendations on the remainder of the schedule at an

carly date
"'I am happy to approve the medical fee increases
"Tam happy to approve the medical fee increases unanimously recommended to me by the committee of reference, representatives of all groups concerned in workmen's compensation, which has been studying this matter,' Miss Donlon said. 'The obligation of employers under the New York law to pay for medical care of industrially disabled workers imposes on the medical profession the duty of rendering the best possible care in workmen's compensation I hope this fair recognition of increased medical costs will encourage doctors throughout the State to give to disabled workers the professional

services they require, and for which industry pays'
"The new rules adopted by the Chairman of the
Workmen's Compensation Board and referred to

above, follow

# Medical Fee Schedule

"'By virtue of the authority vested in me by Sections 13(a) and 141 of the Workmen's Compensation Law, I, Mary Donlon, Chairman of the Workmen's Compensation Board, hereby promulgate the following rule establishing a revision in the schedule of fees for medical treatment and care under the Workmen's Compensation Law for the State of New Lory

"The medical fee schedule heretofore established by the Industrial Commissioner of the State of New York, as last amended by rule promulgated March 8, 1941, and adopted by the Chairman on April 2,

1945, is further amended by these rules
"1 Items. lines numbered 49 to 55. Items, lines numbered 49 to 55, inclusive, of the medical fee schedule are amended, effective as herein provided, as follows

ine No		r ee
49	First visit, home call, in-	
	cluding examination	\$5 00
50	First visit, office call, in-	
	cluding examination	3 50
51	Office call	2 50
52	Home call, other than	
	night emergency	4 00
53	Home call, night emerg-	
	ency (call received by	
	doctor between 10 00	
	PM and 7 OOAM)	6 00
54	Hospital call, other than	
	night emergency	2 50
55	Consultation of attend-	
	ing physician with spe-	
	cialist, attending physi-	
	cian's fee, same fce as	
	regular call or visit	

There is established the following new item.

line numbered 54(a) 51(a) Hospital call, night emer-

gency (call received by doc tor between 10 00 Pu and 7 00 AM)

" '3 Item line numbered 21, providing for a discount of 5 per cent on all medical bills in amounts of \$15 or more, if paid within 30 days, is hereby rescinded, effective as herein provided

Rules 1 and 2 above shall become effective June 1, 1947, and shall be applicable to medical care and treatment rendered under the Workmen's Compensation Law in new cases arising or old cases reopened on and after that date. With respect to medical care and treatment rendered on and after June 1, 1947, in pending cases that arose

prior to June 1, 1947, the provisions of the present fee schedule shall continue to be effective

Rule 3 above shall become effective June 1. 1947, with respect to all bills rendered on and after that date"

There are also attached a few orders of the Chair man, which will be given to the Reference Committee for study, and on which they will bring in their report for your approval (Applause)

The documents referred to by Dr Dattelbaum are

as follows

# Order of the Chairman

"Under and by virtue of the powers vested in me by law, I, Mary Donlon, Chairman of the Workmen's Compensation Board, hereby amend the Rules and Procedure under Sections 13 to 13-,, inclusive, of the Workmen's Compensation Law, as last promulgated on December 30, 1946, as herein provided, namely, "Rule 3 of the Rules and Procedure under Sections 12 to 12, transfer the cedure under Sections 13 to 13-1, inclusive, of the Workmen s Compensation Lan as last promulgated on December 30, 1946, is hereby repealed and new Rule 3 is hereby promulgated to read as follows

In order to expedite the processing of claims of disabled workers for workmen's compensation benefits and to avoid, as far as possible, appearance of physicians in con-tested bill proceedings, the rules with respect to filing of medical reports by attending All medical rephysician are here stated ports filed by attending physicians and specialists must contain the authorization cer-

tificate number and code letters

"Each physician shall file directly with the Chairman and also with the employer the follow-

ing report
"Within forty-eight hours following first treatment, a notice on form C-104, giving all infor-

mation required by such notice

"Within fifteen days after filing form C-104, and in no event later than seventeen days after first treatment, a complete report of injury and treatment on form C-4, giving all information required by such form

"During continuing treatment, a progress report or form C-14 at intervals of not less than

three weeks

"A final report on form C-14 immediately upon termination of treatment regardless of the last

Previous report C-14

'If the patient is discharged from treatment within forty-eight hours after first treatment, only the C-4 report shall be filed, and such C-4 report shall be marked 'Final'

"Additional or more frequent reports may be

required by the Chairman

"Whenever a report is filed with the Chairman by an attending physician after the time period for filing as provided herein and in Section 13-a (4) has clapsed, the physician shall attach thereto a signed and verified statement giving the true reason for which he requests excuse for late filing

'This rule shall become effective immediately on filing in the Office of the Department of State

SPEAKER ANDRESEN Thank you, Dr Datter-baum! The report will be referred to the Reference Committee on the Report of the Council, Part X, and you will hear about it tomorrow any other supplementary reports?

There was no response

Line Sumber Present Schedul	Line \umber Hoesety Proposal	Itera	Present Fee	Medical Society Proposed Fee	Proposed Fee
40	3	First visit home call including examination	\$4 00	\$5 00	\$5.00
50	1	First visit office call including examination	3 00	5 00	3 30
51	2	Office call	2 00	3 00	2 50
52	4	Home call other than night emergency	3 00	4 00	4 00
52 53	5	Home call night emergency (call received by doctor be-			
		tween 10 r M and 7 A M)	5 00	0.00	6 00
54	<u>6</u>	Hospital call other than night emergency	00	3 00	50
	_	Hospital call, night emergency (call received by doctor between 10 r x and A x )		5 00	5 00
\$5	8	Consultation f attending physician with specialist attending plysician a fee same fee as regular call or visit		5 00	

SPEAKER INDRESEN If there are none we will continue with our other business

Section 19 (Sec 52)

#### Introduction of Representatives from Other State Societies

SPEAKER INDRESEN We have always enjoyed having with us delegates from our puis aboring state societies, and I now wish to call on any that may be here to come to the platform and give us a few

words if they will

From the State of Connecticut, Dr Joseph II
Howard, Past President I will ask Dr Kenney to escort him to the platform to say a few words

There was applause as Dr J Stanley Lennoy escorted Dr Joseph H Howard to the platform

DR. JOSEPH H HOWARD Mr Speaker Dr Buuer and Members of the House I am very happy to bring you greetings from the Connecticut State Medical Society Unfortunately frequently our meetings are held at the same time so we are not able to get over here

I was particularly anxious to come today because your delegate to our meeting last week after spend ing a morning seeing how our House functioned remarked that we were using some Tanumany technics in our meetings because they ran so smoothly assured me we would not see such a thing in New York State so I am anxious to see how you function in New York.

On behalf of my friends and colleagues in Con necticut I hope you have a very very successful

meeting. (Applause) SPEAKER ANDRESEN

From the State of New Jersey is Dr James F Nor ton Delegate here or Dr D Ward Scanlan Alter natel

There was applause as Dr D Ward Scanlan

Thank you Dr Howard!

SPEAKER ANDRESEN From the State of Penn sylvania, Dr Elmer Heas the President Elect is here and I will ask Dr Roy Henline to escort him to the platform

There was applause as Dr Roy B Henline excerted Dr Elmer Hess to the platform

DR. ELMER HESS Mr President, Mr Speaker, and may I say Fellow Members of the House of Delegates of the Medical Society of the State of New lork, it is a real pleasure for me to bring you greet

ings from my state society

I would like to get serious for just a moment if I might and say that you and I have no idea how close we came to losing the most precious thing in American life to us the private practice of medicine to the political efforts of the great mass of medical men over this country we were able to forestall this regimentation of our profession but do not think the battle is over In my opinion it has just begun and I believe that when they regiment us they de-

stroy the American way of life completely It is time for us to stand and be counted either are or we are not Americans The job of doing a good public relations treatment if you want to call it such is not propaganda from the state or county societies but it is the individual job that each one of you do in your offices and at the bedside with your sick patients. There is no more powerful political influence in this country than the influence that you have as an individual as you go about your daily work. Unfortunately the men who need that sort of advice seldom come to medical meetings and we are judged very often unfortunately by the actions of the few the public forgetting the great things done by the many

Thank you so much for the privilege of being here with you and greeting my old friend Dr Bauer as

your President (Applause)

SPEAKER ANDRESEN Is then a representative here from Vermont Dr D Dexter Davis? Dr Davis is a former New Yorker a former Brooklynite

There was no response SPEAKER ANDRESEY We are very much pleased to have there delegates from neighboring states here and we hope they will enjoy the sessions and will stay to see how we carry on our business here expect to have quite a lively session here tomorrow

#### Section 20 (See 31-44)

#### Announcements

SPEAKER ANDRESEN I wish to announce that there is going to be a banquet this evening for the members of the House of Delegates and that the tickets for it will be on sale in the hall Any body who wants to go tonight be sure and go there early to buy your ticket As I said before they will be on sale outside in the hall

# Section £1

#### Recognition of Dr Robert Brittain

We would now like to in SPEAKER ANDRESEN troduce our oldest member of the House Dr Robert Brittain of Delaware who has been a member for

over fifty years (Applause)

DR. ROBERT BRITTAIN Delaware Mr Speaker and Members of the House it gives me great pleasure to stand here before you as an old settler I feel that I am sort of blocking so many of the younger men and men who are perhaps so much further advanced in the medical science than I am by being here. I started in with horseshoes and horses and then I came along to the day where we have automobiles I don t know that I enjoy my practice any more with the car than I did with the good old horse One thing I could do with a horse that I cannot do with a car is I could sleep going

(Laughter) There are too many rocks and side hills with a car for me to enjoy doing that in one

It gives me great pleasure to have been introduced by your Speaker, and I hope that we will all be pleased with our meeting this year—I thank you for this opportunity to speak to you (Applause)

SPEAKER ANDRESEN—Thank you, Dr Brittain!

I hope that you will get another good speech ready for us for next year's session, when we will introduce

you agam

The floor is now open for the introduction of resolutions

Section 22 (See 114)

# Distribution of Medical Care

DR REGINALD A HIGGONS, Westchester Mr Speaker, I would like to offer a few words of explanation as to why Westchester puts this resolution in at this time Being a suburban county near a large urban center, we have a population of about 600,000, and we have 1,200 known physicians Of those 1,200, 200 have entered the county within the last eighteen months, and of those 200 we already have personal word that some are leaving due to their inability to make a living Our ratio of doctors to population is now about 1 to 500, and still they are being sent out to Westchester from the urban center on the advice of various people, therefore, we are putting in this resolution

"Whereas, the proper distribution of medical care is one of the major problems to be solved by present-day organized medicine if bureaucratic controls over medical practice are to be avoided,

"WHEREAS, since the war there appears to have been a trend towards even greater concentration of medical practitioners in the large urban and sub-

urban areas, now, therefore, be it "Resolved, that the Medical Society of the State of New York shall collect information from each County Society yearly and shall maintain an up-to-date registry which will enable prospective practitioners of medicine to determine with greater accuracy which communities in the State have need for their particular type of service and which communities already have adequate medical care. and be it further
"Resolved, that the existence of such a registry

shall be publicized through the State Journal of Medicine, the faculties of all grade A medical schools, and the chief of staff of each hospital approved for intern training in the State of New

York "

I would just like to say one more word in clarification Remember that the words "up-to-date registry" as used in the resolution do not apply to WORK that has already been done
SPEAKER ANDRESEN That will be referred to the

Reference Committee on New Business A, of which Dr Leo F Simpson is Chairman

Section 23 (See 129)

# Basic Science Law

DR CHARLES GULLO, Livingston This is introduced by the Livingston County Medical Society and concerns the Basic Science Law

"Whereas, the intent of the resolution of Dr George Cottis made before this House of Delegates in October, 1945, was that an abstract be printed of the essential points of the Basic Science Law, showing where it has worked and where it has not worked, why it has not worked, and whether the American Medical Association is wrong when it goes to the trouble of preparing a

model act for us to follow, and
"Where is, the Medical Practice Committee in its present report does not contain certain factual material necessary for its members to arrive at a proper decision as to the desirability for an ideal Basic Science Law for New York State as a safeguard to prevent the licensing of cults and at the same time to serve to implement the Medical Practice Act in order to prevent the circumvention of the Medical Practice Act, therefore, be it "Resolved, that there be a full discussion on the

floor in executive session with the House of Delegates serving as a committee of the whole, and that each County be given the opportunity to ex-

press some opinion upon this question

That resolution will be re-SPEAKER ANDRESEN ferred to the Reference Committee on Report of the Council, Part IX, on Medical Education

Section 24 (Sec 111)

# General Practitioner in the Practice of Medicine

Dr Benjamin M Bernstein, Kings resolution has for its purpose the restoration of the family doctor, which may prove to be the salvation of the practice of medicine. That is a large order, isn't it? It reads

"WHEREAS, the family doctor is the cornerstone in the practice of medicine, and

"WHEREAS, it is most urgent that the rightful place of the family doctor in the present and future

scheme of medical service be retained, and "Whereas, the development and growth of specialty boards are inimical to the best interests of the family doctor for whom no provision of certification or similar recognition is being made,

"WHEREAS, the acclaim given to the certified specialist in the hospital is rapidly tending to oust the family doctor from any position on a hospital

staff, and "Whereas, consideration being given to the establishment of group clinics likewise tends to the demoralization of the family doctor, and "Whereas, the incentive accorded the certified

specialists for intensive preparation for certifica tion and continued study is being neglected for the

family doctor, and
"Whereas, the declassification of the family
doctor in the estimation of the patient is to the detriment of the future of medical practice, and

"WHEREAS, it is to be noted that in this resolution the term used is family doctor rather than

general practitioner, be it
"Resolved, that a conference be called by the

House of Delegates of the American Medical Association consisting of representatives from the College of Surgeons, College of Physicians, the American Hospital Association, and the various specialty boards, in order to plan the future of the family doctor in future practice and in hospital organization

That resolution will be re-SPEAKER ANDRESEN ferred to the Reference Committee on Report of the Council, Part VI, of which Dr Edward P Flood is Chairman

Section 25 (Sec 77-115) Specialty Boards

DR FRANK LAGUTTUTA, Bronz Mr Speaker this resolution is presented by the Bronx County Medical Society through its delegates

"Whereas, affiliation of all physicians in the United States with some hospital as a means of professional improvement and mutual benefit has been the admitted aim of the American Medical Association and

Whereas many hospitals, the number in creasing constantly are taking measures which tend to restrict and limit such affiliations in order to satisfy requirements established by the numer

ous specialty boards, and

WHEREAS, these requirements of the numerous self-appointed and self-perpetuating specialty boards are arbitrary, discriminatory monopoli-tic, and often variable and contradictory and WHEREAS it has been accepted as a first prin

ciple in the administration of American Justice that a man be judged by a jury of his peers drawn

from his local community and

WHEREAS, educators concede that the determination of ability aptitude and training by a method that depends largely on an isolated ex amination presented under conditions of extreme pressure is unsatisfactory inefficient and unjust and

Wineress this entire problem presents a chal-lenge to Organized Medicine, to the ability of the American Medical Association to regulate itself with justice to all its members to the sincerity of Organized Medicine in its attempt to advance the Public Health and Welfare through the improve-ment of professional standards therefore, be it "Resolved, that the Bronx County Medical

Society through its Delegates request the Medical Society of the State of New York to take such measures to arrest and correct this iniquitous situation until such time as means may be found to place certification of specialists on a more reasonable democratic and local basis and be it further

Resolved that failing to obtain cooperation from the various specialty boards within a reason able period of time the American Medical Association be requested to withhold recognition from hospitals which make certification by a specialty board a necessary qualification for appointment or promotion on a hospital staff

SPEAKER ANDRESEN Referred to the Reference Committee on New Business A of which Dr Leo F Simpson is the Chairman

#### Section 20 (See 113) Group Practice

Dr. Scott Lond Smith (District Delegate) resolution is designed to clarify the conditions under which doctors may work in group practice and employment by health associations, which recent legislation in the State of New York makes legal

"WHEREAS the complexity of medical knowledge makes necessary close cooperation of practicing physicians and pooling of their various

skills, and
Whereas, recent enactment of laws in this state makes legal provision for such combinations and associations in the practice of modicine in the several specialties and

"I HEREAR possibilities of othical abuse under such legal permission are not inconsiderable and

"Wheneas, further enactment of law broadens the conditions under which corporations and associations of laymen may employ physicians in furnishing medical care for their subscribing mem bers, therefore be it

'Resolved that the Council of the New York State Modical Society be requested to furnish in as much detail as possible the partnership and group practice regulations financial agreements and possible participation with laymen under which the members of Organized Medicine may practice their profession

SPEAKER ANDRESEN Referred to the Reference Committee on Report of the Council Part VI of which Dr Edward P Flood is Chairman

Section 27 (See 112) Group Practice

DR. ALFRED M. HELLMAN New York resolution on Group Practice presented at the request of the Medical Society of the County of New

"Witereas group practice is of increasing in terest in the profession because of various prepay ment plans which seek to encourage the practice of medicine in groups and

Where As, there are no largely accepted prin ciples or rules governing the practice of medicine

in groups and Wheneas it is desirable that the American Medical Association supervise this development rather than forfeiting it to organizations not affiliated with Organized Medicine therefore be

'Resolved that the delegates of the Medical Society of the State of New York instruct its delegates to the American Medical Association to propose a resolution to that body that will bring about the provision by the American Medical Association for the establishment of a bureau or council on group practice the functions of such bureau will be (a) To serve as a clearing house of information

on group practice throughout the United

States

To formulate professional ethical and other principles governing the develop-

ment of such group practice
And ultimately at its discretion to provide for qualifications and recognition of groups engaged in group practice in the various parts of this country

That will be referred also SPEAKER ANDRESEN to the Reference Committee on Report of the Council Part VI of which Dr Edward P Flood is Chair

Section 38 (See 95-150)

Establishment of Organization Section in the New York State Journal of Medicine

DE. FRIDERICK W WILLIAMS, Bronz This resolution is also presented on behalf of the Bronz County Medical Society

WREREAS, sound functioning of a democratic organization is dependent upon an informed alec-

Totate and WHEREAS our New York State Medical Sool ety especially the House of Delegates is such a democratic organization, and
Whereas the Council acts for the State Soci

ety between ressions of the House of Delegates and

"Whereas, it is the custom to publish the reports of the Officers, Council, and Standing Committees in the April 1 and April 15 editions of the New York State Journal of Medicine just preceding the annual meeting of the House of Delegates, and

"Whereas, this custom allows insufficient time for study and deliberation by the representative county societies to enable them to instruct their

delegates, therefore, be it "Resolved, that the House of Delegates of the Medical Society of the State of New York direct the Publications Committee to establish an Organization Section in the New York State Journal of Medicine similar to that of the Journal of The American Medical Association, and be it further

"Resolved, that there shall be published in this section all minutes of Council meetings, progress reports of all standing and special committees, and any additional information which the Council

may direct, and be it further "Resolved, that the annual reports be published in the March 15 and April 1 issues of the New York State Journal of Medicine"

SPEAKER ANDRESEN Referred to Reference Committee on Report of the Council, Part XI, Publication, of which Dr Eugene H Coon, of Nassau, is Chairman

Section 29 (See 60)

# Equal Privileges for Returning Veterans (Treatment of Veterans)

Dr. WILLIAM OSTROW, Kings This resolution is from the Medical Society of the County of Kings

"Whereas, a number of physicians, citizens of the United States, graduates from foreign medical schools, the majority of whom are members of the Medical Society of the State of New York, honorably served as commissioned officers in the armed

forces, and "Whereas, these veterans were licensed to

practice medicine in the State of New York, and "Whereas, these veterans now find that the Veterans Administration of the United States is not according them the same privileges to treat veterans as are accorded to the graduates of American schools, be it

"Resolved, that the House of Delegates go on record as favoring and urging the Veterans Administration to give these medical veterans the same status as is given to the veterans who graduated from American schools, and be it further

"Resolved, that a copy of this resolution be printed in the State Medical Journal and copies of this resolution be forwarded to the Veterans Administration of the United States and to the coordinator of the Veterans Bureau in New York"

SPEAKER ANDRESEN Referred to the Reference Committee on Report of the Council, Part VIII. Veterans' Affairs

Section 30 (See 62)

# Equal Privileges for Returning Veterans (Postgraduate Training)

DR WILLIAM OSTROW, Kings This is another one pertaining to the same subject, equal privileges for returning veterans

"Whereas, a number of physicians, citizens of the United States, graduates from foreign medical schools, the majority of whom are members of the Medical Society of the State of New York, honorably served as commissioned officers in the armed forces, and

"Whereas, these veterans were licensed to practice medicine in the State of New York, and "WHEREAS, these veterans now find that they

are denied the same opportunities for postgraduate study and training in accredited medical colleges and hospitals as the graduates of American col-

leges, be it
"Resolved, that the House of Delegates go on record as favoring that these veterans be accorded the same privileges to obtain postgraduate training as the graduates of American schools, and be

it further

"Resolved, that a copy of this resolution be printed in the State Medical Journal and copies of this resolution be forwarded to the colleges and hospitals giving postgraduate instruction in the State of New York"

That will also be referred Speaker Andresen to the same committee, the Reference Committee on Report of the Council, Part VIII, Veterans' Affairs

Section 31 (See 20-44)

Announcement

I would like to make an SPEAKER ANDRESEN announcement to the effect that the Board of Trustees will have a meeting immediately upon adjournment of this session across the hall

Section 32 (See 96)

# News Releases of American Medical Association

DR SAMUEL GITLOW, Bronx This is introduced on behalf of the Bronx County Medical Society

"Whereas, the American Medical Association issues a news release each Friday on the content of articles appearing in the forthcoming Journal of the American Medical Association, and "Whereas, these releases reach the public

through the newspapers before the physicians have received their Journals containing the complete

articles, and

"WHEREAS, patients partially informed through these releases frequently ask their physicians

about such items, and

"Whereas, these questions have been a source of embarrassment to the medical profession and have tended to affect adversely the confidence placed by the patient in the doctor's knowledge of current scientific advances, therefore be it

"Resolved, that such advance press items either be discontinued altogether or be released after the actual receipt by the medical profession of the

American Association Journal, and be it further "Resolved, that the delegates to the convention of the American Medical Association from the Medical Society of the State of New York be instructed to seek the passage of a similar resolu-

Speaker Andresen Referred to the Reference Committee on Report of the Council, Part XI, of which Dr Eugene H Coon is Chairman

Section 33 (See 98)

# Licensing of X-Ray Departments as Laboratories by Hospitals

DR NELSON W STROHM, Erre This resolution concerns the licensing of x-ray departments as laboratories by hospitals

"WHEREAS there has been enacted a law which permits hospitals to license x-ray departments as

laboratories and

"WHEREAS this law is in conflict with and cir cumvents Chapter 466 of the Education Law of 1914 and Chapter 450 of the Workmen & Compen sation Law of 1944 relative to the division of fees

"WHEREAS this permissive law does not serve the best interests of the citizens of the state especially the ill be it

'Resolved, that the counsel of the Medical Society of the State of New York proceed legally to test the validity of this act or law

SPEAKER ANDRESEN Referred to the Reference Committee on Report of the Council Part IN Legislation.

# Section 34 (See 61)

Veterans' Dues

DR. Ezra A. Wolff Queens This resolution is introduced at the instruction of the Medical Society of the County of Queens

"WHEREAS the House of Delegates has adopted the principle of modifying payment of dues by members of the Medical Society of the State of New York in active military service for the dura tion of such service and

'Whereas so-called 'terminal leave is included in the term of active service therefore, be

' Resolved that the period of modified dues pay ment be calculated from the end, not the begin ning, of the terminal leave

SPEAKER ANDRESEN Referred to Reference Committee on Report of the Council Part VIII Veterans' Affairs

#### Section 85 (See 116) Podlatry

Dr. Renato J Azzari, Bronz. This is a resolu tion that has to do with podiatry

"Wireness podiatry is a technical minor ad

junct of orthopedics, and

"WHEREAS, many major systemic diseases have manifestations in lesions of the lower extremity and

WHIREAS The Institute of Podiatry is not a

medical school and

Wheneas, the licensed podiatrists have been active in attempting to pass legislation in this State to extend the limitations of their licensure to include the treatment of systemic disease, and

WHEREAS the treatment of disease constitutes the practice of medicine under the laws of this

State, and
WHERDAS the passage of such legislation
would be detrimental and hazardons to the public health and welfare, therefore be it 'Resolved that the Medical Society of the State

of New York put itself on record as being opposed to such legislation and be it further Resolved that the Governor and members of

both Senate and Assembly be sent copies of this resolution and be it further Resolved that the Legislative Committee and

our Albany representative be instructed to govern themselves accordingly and be it further

Resolved that the content of these resolutions be made known to the Board of Regents of the State of New York.

SPEAKER ANDRESEN Referred to the Reference Committee on New Business C of which Dr Theodore J Curphey is Chairman

Section 36 (See 109)

Furnishing of Medical Service with Hospitalization Insurance

Dr. Sol Axelhad Queens This is a resolution that is brought in on instructions of the County of Queens

"Whereas the services of the pathologist roentgenologist anaesthesiologist and physical therapist are medical services and

"WHEREAS Blue Cross Plans wrongfully offer these services to the public as benefits under hospitalization insurance policies and

WHERDAS, Associated Hospital Service the Blue Cross Plan covering seventeen lower New York State counties has refused to agree to dis-

continue this practice, therefore be it

"Resolved, that the Medical Society of the State
of New York through its House of Delegates expresses its disapproval of such practice and be it

lurtber

Resolved, that the Society shall withdraw its endersement of Associated Hospital Service or other Blue Cross Plan operating in New York State unless the practice of supplying medical service under hospitalization policies is discon tinucd.

SPEAKER ANDRESEN Referred to the Reference Committee on Report of the Council, Part VI on Modical Care

Section 37 (Sec 63)

Medical Consultants in the Veterans Administration

DR BENJAMIN M BERNSTEIN Kings This resolution is introduced on instructions from the Medical Society of the County of Kings

WHEREAS, the Veterans Administration has initiated a policy of appointing part-time medical consultants to supplement their own staff and

WHEREAS, these consultants are selected by committees of deans from medical schools, and WHEREAS it is the policy of these deans to select no consultants except those who are on the

teaching staffs of medical schools, and "Whereas, this policy discriminates against other qualified and competent specialists outside of medical schools and establishes an exclusive monopoly of veteran consultant care and

WHEREAS, this discriminatory practice of con-sultant selection deprives the veteran of some of the best medical skills particularly by veteran physicians who held responsible positions during the war and best understand the problems of the

veteran therefore, be it

Resolved that the Medical Society of the State of New York go on record as being opposed to the present process of selection for consultant Veter ans Administration medical specialists, and that the responsibility for consultant selection bo placed in the hands of an impartial board consist

ing of members of Organized Medicine and the present deans committees Referred to the Reference SPEAKER ANDRESEN Committee on Report of the Council Part VIII

Veterans Affairs

(Sec 8, 47, 102, 104) Section 38 Report of Malpractice Insurance and Defense Board

DR I STANLEY MENNEY Mr Speaker and Members of the House, the Malpractice Insurance and Defense Board felt that they had a message for the House of Delegates of such importance for their guidance in considering the report when it is brought before the House by the Reference Committee tomorrow, and the nature of the information is such that they have requested permission to have an evecutive session in which to impart this information We have no objection to any of the lay secretaries or other responsible associates of the component societies remaining

I, therefore, make a motion, requesting that this House go into executive session for the consideration

of this report
DR. THOMAS J D'ANGELO, Queens I second the

motion

SPEAKER ANDRESEN If Dr Kenney and the House have no objection, we will put off the executive session until the end of the meeting today when all of the resolutions have been presented and can thus be considered by the appropriate reference committees, after which we can have the executive session and then adjourn until tomorrow no objection, we will order that Hearing none, that will be the procedure that we will follow

Section 39 (Sec 70) Activities of the Medical Practice Committee

DR. J. F. PAINTON, Erre Mr. Speaker and Members of the House, this resolution is offered on instructions of the Medical Society of the County of Ene

"Whereas, the Medical Practice Committee of Greater New York, functioning as a state-wide agency of Workmen's Compensation Law, receives application for, and recommends rating and rerating of physicians outside Greater New York,

and
"Whereas, the Medical Practice Committee of
Greater New York has established standards for qualifying physicians throughout the State, and

"WHEREAS, the Medical Practice Committee of Greater New York receives applications for and recommends the licensing of Workmen's Compensation Medical Bureaus outside Greater New

York, and
"Whereas, these acts of the Medical Practice
Committee of Greater New York are an illegal
usurpation of the rights of County Medical Societies outside of Greater New York therefore be it

"Resolved, that the counsel of the Medical Society of the State of New York proceed legally to restrain the Medical Practice Committee's activities as a state-wide agency of Workmen's Compensation Law

SPEAKER ANDRESEN Referred to the Reference Committee on Report of the Council, Part X. Workmen's Compensation

Section 40 (Sec 64)

Medical Indemnity Plan-North Eastern New York Medical Service, Inc.

DR RAYMOND F KIRCHER, Albany This is on the subject of a medical indemnity plan

"The Medical Society of the County of Albany requests the House of Delegates to endorse the North Eastern New York Medical Service, Inc.

Referred to the Reference SPEAKIR ANDRESEN Committee on Report of the Council, Part VII. Medical Care Insurance

Section 41 (See 76)

Amendment to Constitution

DR HOMER J KNICKERBOCKER, Ontario resolution is introduced at the request of the Ontario County Medical Society, in whose area the conditions with which it deals are prevalent and are presumably similar to those which pertain in other areas

'Whereas, certain county medical societies have been privileged to elect Associate Members whose elections have been accomplished by following the same routine applicable to Active Members, and

"Whereas, these Associate Members have been exempt from payment of assessments levied by the

State Society, and 'Whereas, these Associate Members have been granted all the privileges of Active Members ev-

cept that they may not hold elective office, and "WHEREAS, no provision is made in the constitution of the Medical Society of the State of New

York for such membership therefore be it "Resolved, that Article II of said Constitution be amended by the deletion of the word 'three' and the substitution of the word 'four' and the addition of the word 'Associate' under the caption of 'D' thus making the article read, viz

"The membership in this Society shall be divided into four classes (a) Active, (b) Retired, (c) Honorary, (d) Associate

SPEAKER ANDRESEN That will be published before the next meeting of the House, and will be held over until next year and acted upon at that time It being an amendment to the constitution, we cannot take any action on it at this time

DR KNICKERBOCKER It may come up as a substitute for one that has already been published, and

which is along similar lines

SPEAKER ANDRESEN That we were to act on now, at this year's meeting of the House?

DR. KNICKERBOCKER Yes There has been one published that covers the same grounds as this SPEAKER ANDRESEN

That being the case, we will refer it to the Reference Committee on Amendments to the Constitution and Bylaws

Section 42 (See 75) Amendment to Bylaws

of the House

DR HOMER J KNICKERBOCKER, Ontario same ruling would apply to this, which is offered as a substitute for an amendment to the Bylaws already published, and that will be acted on at this meeting

"Whereas, the present Bylaws of the Medical Society of the State of New York make no mention of Associate Membership, therefore be it

"Resolved, that Chapter 1 of the Bylaws entitled 'Membership' shall have added thereto a new section to be known as Section 8 to read as follows

"Section 8 Constituent County Medical Societies may elect Associate Members from among the personnel of US Government facilities located within their jurisdiction by following the same routine as prescribed for the election to Active Membership, except that New York State Registration may not be deemed essential. Associate Members shall be exempt from pay ment of State Medical Society assessments. They shall be accorded all the privileges of Active Membership except voting holding elec-tive office, or being eligible to malpractice de-fense by counsel of the Medical Society of the State of New York.

That will also be referred SPEAKER ANDRESEN to the Reference Committee on Amendments to the Constitution and Bylaws of which Dr Peter J DiNatale is Chairman. As I understand it, both of these are substitutes for amendments already published and that are to be acted upon this year

DR. KNICKERBOCKER Right

Section 43 (See 68) Workmen's Compensation—Upward Revision in Fee Schedule

Dr. George A Burgin Herkimer I have been asked to present this resolution, which may not be as applicable as it was before the Supplementary Report of the Workmen's Compensation Committee was given today but because of lack of full informa tion on that I will present it anyway The follow ing resolution was presented to the Herkimer County Medical Society at its last meeting on April 8 1947 and adopted

"WHEREAS, the Medical Society of the County of Herkimer and numerous other county medical societies of the State of New York have repeatedly, and without success, sought an increase in the Workmen's Compensation fee schedule of the State of New York to bring it more in harmony with the rise in costs of the practice of medicine, therefore be it

"Resolved, that the members of the Medical Society of the County of Herkimer do hereby agree that on and after May 15, 1947, they will consider the existing fee schedule as a minimum schedule only, and that on and after May 15 1947 they will make charges in all new compensation cases coming under their care after that date based upon the present-day standards of medical costs. They further agree to submit to arbitration all such bills as are disputed by the carriers, and be it

Resolved that a copy of this resolution be for warded to the Secretary of the Medical Society of the State of New York and to the Chairman of the Workmen's Compensation Board and be it fur ther

'Resolved that the delegate from this county to the annual meeting of the House of Delegates of the Medical Society of the State of New York, to be held in May 1947 be instructed to present this resolution and aid in every way the State Compensation Bureau in its efforts to secure the proposed changes in the fee schedule

SPEAKER ANDRESEN Referred to the Reference Committee on Report of the Council Part A, Workmen s Compensation.

# Section 44 (See 20 31)

#### Announcement

SPEAKER ANDRESEN I want to make an announcement. Due to a misunderstanding I made a terrible mistake when I told you there were tickets on sale for this ovening. The tickets are for the banquet on Wednesday night. There is no banquet scheduled for tonight.

I would like again to request the Chairmen of the Reference Committees to let Miss Dougherty know when they are going to meet. Are there any further resolutions?

Section 45 (See 69)

Qualifying and Rating of Physicians Under the Workmen's Compensation Law

DR. WILLIAM J ORR (District Delegate) This resolution has to do with the qualifying and grading and rating of physicians under the Workmen's Compensation Law

"Whereas the proper rating and authorization of physicians is vitally essential to the effective accomplishment of the purposes of the Work men s Compensation Law particularly the provi-sion of the highest quality care for injured work

ers, and Whereas, the County Medical Societies of this State have performed a notable job in assisting the Chairman of the Workmen's Compensa tion Board to properly rate and authorize physicions to render medical care to persons entitled to the benefits of the Workmen s Compensation Law and

WHEREAS, the 1947 State Legislature enacted the Condon Bill which empowers the Chairman of the Workmen's Compensation Board to review

and revise physicians compensation ratings and "Wheneas, the Medical Society of the State of New York believes that the County Medical Societies, because of their specialized knowledge familiarity with local conditions, and with the status of the status of the specialized knowledge familiarity with local conditions, and with the actual qualifications of physicians are best equipped to determine the character of medical care physicians are qualified to render therefore

be it "Resolved, that the Medical Society of the State House of Delegates, recommend to the Chairman of the Workmen's Compensation Board that revi sions of ratings be made by the County Medical Societies and the Chairman of the Workmens Compensation Board in accordance with the qualifying standards heretofore formulated by the County Medical Societies—and be it further

'Resolved that a copy of this resolution be transmitted by the Secretary of the Medical Society of the State of New York to the Chairman of the Workmen s Compensation Board

Speaker Andresen Referred to the Reference Committee on Report of the Council Part A. Work men a Compensation

#### Section 46 (8ee 67)Nursing

ASSISTANT SECRETARY FREY This resolution is introduced by the Council Committee on Nursing at the request of the Coordinating Council on Nursing Problems which has representatives from the State Medical Society the State Hospital Administrators Association, the State Nurses Association and the Practical Nurses

"WHEREAS, there is an over all shortage of nurses both registered professional and practical,

in New York State, and 'Wheneas, nursing is a noble and an attractive profession and

WHEREAS physicians have a special opportunity to present the advantages of a nursing career to the daughters and sons of their patients therefore be it

"Resolved, that this House of Delegates recommend that the Members of the Medical Society of the State of New York use their influence individually and personally to further the recruitment of candidates for nurses' training schools, both registered professional and practical, throughout the state"

That will be referred to the SPEAKER ANDRESEN Reference Committee on Report of the Council, Part XII, of which Dr Joseph Geis is Chairman

Are there any further resolutions?

There was no response

In that case we will con-SPEAKER ANDRESEN

sider going into executive session

The motion was put to a vote, to go into executive session to hear the report of the Malpractice Insurance and Defense Board

(See 8, 38, 102, 104)

Report of Malpractice Insurance and Defense Board

SPEAKER ANDRESEN We will appoint as Sergeant-at-Arms, Dr Charles F McCarty, of Kings, and as his assistants Dr Ezra A Wolff, of Queens, Dr Frank LaGattuta, of Bronx, Dr David Corcoran, of Suffolk, and Dr Elton R Dickson, of Broome

The Sergeant-at-Arms and his assistants will clear the House of all except delegates In the past it has been customary to allow to remain also—and we will continue that practice unless there is objection—the Executive Secretaries of the county societies, the Executive Officer of the State Society, Mr Wanvig, our insurance adviser, our counsels, Mr Martin and Mr Clearwater, and the Executive Secretary of the State Board of Medical Examiners, Dr Lochner

Dr George W Kosmak May I ask that there be included in that the Editorial Board of the

JOURNAL.

SPEAKER ANDRESEN Also the Editorial Board

of the JOURNAL.

DR EDWARD R CUNNIFFE What about the delegates who are visiting us from other state societies?

SPEAKER ANDRESEN They are also entitled to stay, having been delegated to come here from other state medical societies

Dr Benjamin M Bernstein, Kings

about alternates?

SPEAKER ANDRESEN A suggestion has been made that any alternates who are here may also be Is there any objection to that? allowed to stay

Hearing none, it is so ordered

The president of one of our county societies is He is not a delegate, and he wants to get the consensus of opinion of the House as to whether the presidents of the county societies who are here and who are not members of the House should be allowed It has not been customary to allow to remain them to do so in the past

DR CHARLES GORDON HEYD (Past-President)

so move

The motion was seconded by several, and as there was no discussion, it was put to a vote and was unanimously carried

DR McCarty I wish to report that the House has been cleared of all those who were not entitled to remain to the Evecutive Session

I declare the House of SPEAKER ANDRESEN

Delegates now to be in executive session

At this point the House went into executive session, at the conclusion of which a resolution was presented by President Bauer, and was referred by the Speaker to the Reference Committee on Report of the Malpractice Insurance and Defense Board

The action on this resolution appears under Section 104

Section 48 (See 71)

Workmen's Compensation—Fee Schedule

DR A F GAFFNEY, Oneida This resolution has been handled already by the announcement made this morning, but since we were asked to present it on behalf of the Medical Society of the County of Oneida, we will do so

"WHEREAS, the cost of medical practice has markedly increased since the present fee schedule of the Workmen's Compensation Department was revised, and

"Whereas, the fees of private practice in the County of Oneida have increased due to the rise of

the cost of medical practice, be it

"Resolved, that the delegates to the State Convention from Oneida County be instructed to present to the House of Delegates of the State Society a resolution asking for an increase in the workmen's compensation fee schedule '

Referred to the Reference Speaker Andresen Committee on Report of the Council, Part X, Workmen's Compensation

Section 49 (See 127)

Conditions Governing the Relationships Between the Hospitals and the Specialists of Laboratory Medicine in the State

DR STEPHEN H CURTIS (Section Delegate) resolution is introduced at the request of the New York State Society of Pathologists and the Section on Pathology, and it concerns conditions governing the relationships between the hospitals and the specialists of laboratory medicine in the State

"Whereas, it has been established by the American Medical Association that the practice of Pathology is the practice of Medicine, and

"WHEREAS, many of the recent advances in the field of medicine are districtly attributable to the contribution of the workers in the field of laboratory research and the practical application thereof

in the field of clinical medicine, and
"Whereas, the practitioner of medicine wel
comes and utilizes fully the scientific help supplied by these practitioners of laboratory medi

"WHEREAS, in the hospitals of this country there now exists an intolerable situation by which the natural expansion of Laboratory Medicine is

being retarded

Through the improper and arbitrary con-(a) trol of the scientific and administrative efforts of this group of medical practitioners, and

By the extensive economic exploitation by the institutions of the scientific efforts of

this group, and

"WHEREAS, it is the feeling that the present ex-isting situation will diminish the number of younger men entering the ranks of this specialty. thus seriously depleting a growing and increasingly useful branch of medical practice, now be it "Resolved, that the House of Delegates of the

Medical Society of the State of New York give cognizance to the existing situation, and be it

further

"Resolved, that the situation be carefully studied by the Society with the avowed purpose of developing a new pattern of practice of the specialty

[Continued on page 1920]

#### ABSTRACT OF MINUTES OF THE COUNCIL OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

THE Council held its organization meeting on Wednesday May 7 1917 at the Memorial Audi torium Buffalo New York In addition to minor routine matters the Council took action on the following

Secretary & Report

Remission of State Assessments -The remission of State assessments was voted on account of service with the armed forces for 59 members for 1947 and 52 for 1946 also on account of illness for Drs. Joseph W Goldsmith, Max Lederer Eugene W Martz, Joseph F Morris Philip Oginz, Herbert 8 Pierson Lorne McD Ryan Isalah R. Shapiro S Aleville Skinner, Alexander A Stone Fred Washnitzer and Edwin B Wilson

At its meeting on June 19 1917 the Council considered various matters taking final action or direct ing further study and reports as indicated under the following headings.

### Secretary's Report

Remission of State Assessments.—The remission of State assessments was voted on account of service with the armed forces for 445 members for 1947 47 for 1946 8 each for 1945 1944 1943 and 1942 and 2 for 1941, also on account of illness for Drs Julius B Boehm, Alex M. Gluckstein, Sidney H Saffer Herman W Taylor, and Irving Traun. Meetings Attended.—After returning from Buf

falo on May 10 your Secretary visited Philadelphla on May 22 to attend the Middle Atlantic States Regional Conference on Medical Service of the American Medical Association. The Society also was represented by Drs Aranow Kenney, and Red way and Mr Farrell Dr Thomas A. McGoldrick was also present as vice-chairman of the Conference. The subjects on the program were

Present status of United Mine Workers

Medical Health Program

2. Organized Medicine s Relationship to the various cancer drives

The present Taft-Smith Donnell Bill

The Hill Burton Bill

Changes in the Medical Policy of the U.S Veterans Administration

There was considerable discussion of each topic, particularly the last.

Also during lunch Mr J William Holloway Jr of the Legal Department of the American Medical Association discussed the present legislative situation in Washington.

House of Delegates Matters Taken Care of -The directives of the House of Delegates have been fulfilled by your Secretary in such matters as notify ing all constituent county socretaries and treasurers regarding the 1948 State assessment and the inter pretation that the severance date when members eave the armed forces is to be considered the end of terminal leave.

A copy of the resolution which decries the existing method of appointing consultants to the Veterans Administration facilities was sent to each of the New York State modical college deans.

Your Secretary has contacted Dr Robert R. Hannon, Executive Officer and is in the process of asking the Chairman of Scientific Sections to appoint legislative advisory committees as approved by the

House of Delegates

In accordance with the House of Delegates direc tive Mr William F Martin Counsel has been asked for an opinion regarding review and revision of ratings of physicians under an amendment of the Workmen's Compensation law Copies of the House of Delegates resolution re-

garding medical services for veterans have been for warded to Honorable Harry S. Truman, President of the United States of America, and General Omar

N Bradley, U.S Veterans Administration. Copies of a resolution passed by the House of Del egates regarding equal privileges for returning vet-erans in postgraduate study and training in medical colleges and hospitals for graduates of domestic and foreign medical schools, have been sent to the deans of medical colleges in New York State and will be disputched to hospitals as soon as a proper list is compiled

In preparation for the meeting of the American Medical Association House of Delegates each of our delegates was sent a copy of each of the six resolu-tions passed by our own House of Delegates which require presentation at Atlantic City and arrangements were made for a caucus the evening preceding the American Medical Association House of Delegates To this we invited ex Presidents Van Etten and Hoyd, and the two New York State members who were listed as delegates from A.M A. Sections as well as Dr. Hannon and Mr. Anderson.

#### House of Delegates Matters Referred to Council for Action

Partnership and Group Practice Legislation

Your Reference Committee endorses the rec ommendation of the Planning Committee that this House of Dukgates authorize the Council to have drafted suitable legislation to cover the matter of partnerships and group practice within the principles already approved by the State Society and that in the drafting of this proposed legislation, other interested agencies be consulted and their aid and cooperation solicited

After discussion

It was voted to refer this matter to the Legisla tive Committee.

Contract with Kings County Medical Society

"We have read the supplementary report of the Council Committee on Contract with Kings County Medical Society

'We agree that the Editor of the JOURNAL should be privileged to state to whom books should be sent for review that the books remain in the hands of the reviewer and furthermore that the Editor of the Journal should have ready for reference all

journals received for a definite period

"These requests necessitate a modification of the contract. In order to accomplish this, your Reference Committee recommends that this matter be referred to the Council in conjunction with the Comitia Minora of the Kings County Society for their determination and such reference as may be needed in relation to the continuance or the termination of such a contract.

After discussion,

It was roted that the matter be referred to the legal counsel of the two societies for preliminary report

and then have it taken up by a Joint Committee of the Council and of the Comitia Minora of the Kings County Society

Licensing of X-Ray Departments as Laboratories

"WHEREAS, there has been enacted a law which permits hospitals to license x-ray departments as laboratories, and

"WHEREAS, this law is in conflict and circumvents Chapter 466 of the Education Law of 1944 and Chapter 459 of the Workmen's Compensation Law of 1944 relative to the division of fees, and

"Whereas, this permissive law does not serve the best interests of the citizens of the State, es-

pecially the ill, be it

"Resolved, that the Counsel of the Medical Society of the State of New York proceed legally to test the validity of this Act or Law"

"Your Reference Committee agrees in principle with the resolution However, because of the many factors involved in preparing a legal testing of the validity of the law, which requires further study. your Reference Committee therefore recommends that this resolution be referred to the Council.

"One of the things that it entails is the expenditure of moneys I don't think we are qualified to give you a definite opinion on that"

Employment of Radiologists by Hospitals, on Salary

"Whereas, the 1947 State Legislature enacted an amendment to Section 13-c(2) of the Workmen's Compensation Law which permits hospitals to employ radiologists on a salary basis, and

"WHEREAS, this new law is inconsistent and is in conflict with Section 1261-4 of the Education Law and Section 13-d(2g) of the Workmen's Compensation Law, which prevent hospitals from employing radiologists on a salary basis, and "Whereas, these statutes will result in a great

deal of confusion in the minds of radiologists as to

whother they may accept a salary, therefore, be it "Resolved, that the Counsel of the Medical Society of the State of New York take legal steps to secure an interpretation of the statutes relating to the permissible financial relationship between hos-

pitals and radiologists
"Whereas, this resolution and the previous one are closely related, your Reference Committee recommends the same action as upon the previous one, namely, that it be referred to the Council of the Med-

ical Society of the State of New York.'

After discussion.

It was voted to refer the above resolutions to the Legislative Committee and the Legal Counsel for study and report at the next meeting of the Councıl

# X-Ray Diagnosis

"Whereas, a bill to amend Section 1250 of the Education Law of the State of New York in relation to practice of x-ray diagnosis and treatment, and treatment by radium was introduced in the 1947 legislature, which bill was not passed, there-

fore, be it "Resolved, that the Medical Society of the State

the New York State Legislature in 1948 as follows "X-ray diagnosis means that method of medical practice in which demonstration and examination of the normal and abnormal structures, parts or function of the human body are made by use of x-rays, and any person who holds himself out to diagnose or able to make or makes any interpretation or explanation by word of mouth writing, or otherwise, by the meaning of a fluoroscopic or registered shadow or shadows of any part of the human body made by the use of xrays, and also the use of x-rays or radium for the treatment of any human ailment, shall be deemed to be engaged in the practice of medi eine within the meaning of this article, and Section 1262, as follows The provision of this article shall be deemed to prohibit the practice of x-ray diagnosis, x-ray therapy, or radium therapy, as defined in subdivision 7-A of Section 1250 of this Chapter by any person other than a person licensed as a physician, a dentist, an osteopath, or a podiatrist "Be it further

"Resolved, that the Medical Society of the State of New York actively work for the passage of such a bill in the Legislature during the year of 1948" This resolution was approved in principle and referred to Council for proper wording

After discussion.

It was voted to refer the above resolution to the Legislative Committee for necessary action

Group Practice

"Resolved, that the Council of the Medical Society of the State of New York be requested to furnish in as much detail as possible the partnership and group practice regulations, financial agreements, and permissible participation with laymen, under which the members of Organized Medicine may practice their profession" After discussion.

It was voted that the above resolution be referred to the Planning Committee in consultation with the Committee on Ethics, and such other groups as the Committee deems advisable

# Distribution of Medical Care

"Resolved, that the Medical Society of the State of New York shall collect information from each County Society yearly, and shall maintain an up-to-date registry which will enable prospec-tive practitioners of medicine to determine with greater accuracy which communities in the State have need for their particular type of service and which communities already have adequate medical care, and be it further

"Resolved, that the existence of such a registry shall be publicized through the NEW YORK STATE JOURNAL OF MEDICINE, the faculties of all Grade A medical schools, and the chief of staff of each hospital approved for intern training in the State

of New York."

"Your Reference Committee believes that the purpose of this resolution will be adequately served by the issuance of the new medical directory of the State of New York within a few months, and that the establishment of such a registry would be an unnecessary expense to the Society

"We believe also that this type of information is rarely sought for by prospective practitioners, and that the stimulus for them to do so should originate

in the medical schools and hospitals

Your Committee suggests that the Medical Society of the State of New York, through its publications and by any other available means, solicit the cooperation of the medical schools and hospitals in this matter

"Your Committee recommends that this resolution be referred to the Council for consideration and

action '

It was roted to refer this to the Publication Committee for study and report.

Podiatry

"Whereas podiatry is a technical minor ad junct of orthopedies and

"Whereas many major systemic diseases have manifestations in lesions of the lower extremity.

"WHEREAS, the Institute of Podairty is not a

medical school, and 'Wheneas the licensed podiatrists have been active in attempting to pass legislation in this State to extend the limitations of their licensure to include the treatment of systemic disease and

"Whereas the treatment of disease constitutes the practice of medicine under the laws of this

State, and
"Whereas, the passage of such legislation
would be detrimental and hazardous to the public

health and welfare therefore, be it Resolved, that the Medical Society of the State

of New York put itself on record as being opposed to such legislation, and be it further
Resolved that the Governor and members

of both Senate and Assembly be sent copies of this

resolution and be it further

"Resolved that the Legislative Committee and our Albany representative be instructed to govern themselves accordingly and be it further

Resolved that the content of these resolutions be made known to the Board of Regents of the

State of New York.'

Referred to the Council Committee on Legislation in order that more vigorous opposition to any proposed legislation in this connection shall be fortered directly by the New York State Society After discussion,

It was roted that a Subcommittee be appointed to assist and report to the Legislative Committee, this Subcommittee to consist of Dr Dattelbaum chairman, Dr Mott of the Legislative Committee, and the chairman of the Section on Orthopedics and that they call in representatives of medical education to get their ideas

#### Training of Medical Technicians

Resolved, that the Medical Society of the State of New York memorialize the colleges and universities of the State, urging them to establish a fouryear curriculum for the training of medical technologists including a minimum of one year of su pervised practical experience in an approved hospital and which will lead to a degree in Medical Technology and be it further

Resolved that consideration be given to a limited program consisting of one year in basic courses and one year of practical hospital training in which certification may be granted as a junior grade

medical technologist

Approved in principle. Referred to Council to investigate with the aid of education and medical or ganisations having a similar interest e.g., the New York State Society of Pathologists the Joint Coun cil of Radiologists Pathologists, Anaesthesiologists and Physical Therapy Physicians as well as the Board of Registry of the American Society of Clinical Pathologists and the New York Academy of

It was coled that this be referred to the Subcommittee just appointed.

10 Business Surrey

The recommendation that a business survey of the greatly extended activities of the Society be made was referred to the Committee on Office Administra tion and Policies for study and recommendation.

#### War Memorial

'With respect to the report of the Finance Com mittee regarding the war memorial of the Society which is a proposal for the Society to finance the ad vanced education of the children of its members who died in the military service during World War II your Committee feels that this can only be financed by a special assessment for this purpose. Your Com mittee recommends that this matter be referred to the Council and Trustees for further study as we have no factual or actuarial knowledge as to its preent or ultimate cost.

After discussion.

It was roted that a Subcommittee of four (two from the Council and two from the Trustees) be appointed to study the matter with special emphasis as to what policies the House of Delegates really intended should be followed.

#### Medical Practice Committee

Resolved, we request that the Council of the Modical Society of the State of New York, through its Committee on Legislation be instructed to prepare and introduce legislation calling for the abolition of the Medical Practice Com mittee and the restoration of its functions to the

respective County Societies
Resolved we request that legislation be introduced in the New York State Legislature in the 1948 session to restore to the County Medical So-cleties of Greater New York the powers which they had under the compensation laws of 1935

Your Committee recommends approval of both of these resolutions. After discussion

It was roted that this be referred to the Legislative Committee

Conditions Governing the Relationships Between Hospitals and Specialists in Laboratory Medicine

Resolved that the House of Delegates of the Medical Society of the State of New York give cognisance to the existing situation and be it fur ther

Resolved that the situation be carefully stud ied by the Society with the avowed purpose of developing a new pattern of practice of the specialty of Laboratory Medicine in the hospitals placing such practice on the same broad basis as now gov erns the relationship of medical specialists with the institutions of this State and that a committee be appointed by the President with the ap-proval of the Council to carry out this study

which resolution was introduced at the request of the New York State Society of Pathologists Reference Committee has considered this resolution and after deliberation, recommends that in full realization of the fact that the problem of the labora tory men and their relation to the hospital has been presented to this House in many varied aspects in several resolutions over the years this resolution be approved in principle and that it be referred to the Council for action.

After discussion,

It was roted that this resolution be referred jointly to the Joint Committee of the Hospital Associa tion and the Medical Society and the Committee on Economics.

Communications -Letter of thanks from William Hale, Jr, dated May 20, 1947, was read by Dr An-

derton

Letter from Dr Ezra A Wolff, secretary, Medical Society of the County of Queens, dated May 2 1947, containing a resolution adopted at a special meeting, disapproving the Health Insurance Plan of New York, was read for information by Dr Anderton

Letter dated May 13, 1947, from Onondaga County Medical Society re State Society's attitude about the National Physicians Committee and its component State Committees After discussion.

It was voted that the Council has no objection to a component county medical society appointing a committee to cooperate with the National Physicians Committee, in its own area

Treasurer's Report Was Accepted

# Report of Delegates to the 1947 Meeting of the American Medical Association

To the Council—Gentlemen

The following members represented the Medical Society of the State of New York in the House of Delegates of the American Medical Association at Delegates of the American Medical Association at Atlantic City, New Jersey, June 9, 10, 11, 12, 1947 Thomas A McGoldrick, John J Masterson, Stephen R. Monteith, J Stanley Kenney, George W Kosmak, Thomas M D'Angelo, Harry Aranow, Louis A Van Kleeck, Scott Lord Smith, Walter W Mott, W P Anderton, Herbert H Bauckus, Albert F R Andresen, Clarence G Bandler, James R Reuling, Floyd S Winslow, Relight T B Todd, O. W. H. Mitchell, Edward R. Bandler, James R Reuling, Floyd S Winslow, Ralph T B Todd, O W H Mitchell, Edward P Flood, and Albert A Gartner

Also in attendance at the House of Delegates and at some of the meetings of your delegation were Louis H Bauer, Arthur J Bedell, Edward R Cunnific, Roy B Henline, Charles Gordon Heyd, Nathan B Van Etten, H. G Weiskotten, and Durch Anderson Etc.

Dwight Anderson, Esq Dr Floyd S Winslow was elected Chairman

The delegation met Sunday evening, June 8, 047 At this time Mr Royal Ryan of the New 1947 York Convention and Visitors Bureau, addressed us in regard to having the American Medical Association's Annual Meeting in New York City in 1948 or

Resolutions directed by the House of Delegates of the Medical Society of the State of New York, for introduction at the American Medical Association

House of Delegates were discussed

The resolution on Group Practice was assigned to Dr J Stanley Kenney for introduction This was referred to a Reference Committee which accepted it in principle, and the subject was referred to the proper Council of the American Medical Association

A resolution regarding Hospital Specialty Boards was assigned for introduction to Dr John J Master-The Reference Committee to which it was assigned considered this resolution in company with The House of Delegates other similar resolutions

took sympathetic action

A resolution on Teaching Medical Economics in Medical Schools was introduced by Dr James R Reuling at the request of his fellow delegates After digestion in a Reference Committee, the subject of this resolution was referred to the appropriate

A M A Board
Dr Walter W Mott, upon instruction from his fellow delegates, introduced our resolution regarding This received favorable action Nurses

However, a resolution regarding AMA Neina Releases, introduced by Dr. Harry Aranow, was defeated upon recommendation of the Reference Committee

Dr Herbert H Bauckus's resolution regarding Veterans Administration "Hometown" Care of Service-connected Disabilities received favorable vote

The delegation voted to request Dr Winslow to recommend to the Council that it undertake to establish a mechanism for editing resolutions in the House of Delegates of the Medical Society of the State of New York

A letter from Mr Archibald G Thacher, chairman, Citizens Committee for Military Training of Young Men, Inc, was discussed It was voted for

Dr Winslow to reply

The second meeting of the delegation was held Wednesday, June 11, 1947, after adjournment of the A M A House of Delegates At that time the candidates for elective offices in the American Medical Association, were discussed, the World Health Organization was discussed

It was voted that the chairman appoint a Committee of three to make arrangements for a proper meeting room for your delegation at the next meet-

ing of the American Medical Association

The last meeting of the New York delegation was held between the morning and afternoon sessions on Thursday, June 12, 1947 At that time the delegates agreed about which candidates they would support in the forthcoming election

During this meeting the following members of your delegation were assigned to Reference Com-

mittees

Hygiene and Public Health W P Anderton Legislation and Public Relations T A McGoldrick Medical Edu-(Chairman) G W Kosmak cation Miscellaneous business S R. Monteith On reports of Board of Trustees and Secretary A A Gartner

On reports of

Officers (Chairman) J R Reuling On Sections and Section

Work (Chairman) R B Henline Scott Lord Smith

It gives me pleasure also to report that Dr Thomas A McGoldrick was elected Vice-President of the American Medical Association for 1947 to 1948 unanimously and without an opposition candi-

> Respectfully submitted, FLOYD S WINSLOW, M'D CHAIRMAN

It was voted that felicitations be sent to Dr Mc-Goldrick on his being elected Vice-President of the A.M A

In regard to the recommendation that the Council undertake to establish a mechanism for editing resolutions in the House of Delegates of the Medical Society of the State of New York,

It was voted that a Committee to consist of the Speaker, Vice-Speaker, and Secretary, be appointed to work out some recommendation relative to this, and submit it later to the Council in time for it to be incorporated in the Annual Report

It was voted that the matter of obtaining a proper meeting room for the delegation at the next meeting of the A.M 1. be approved and that the Trustees be requested to appropriate if necessary an amount not to exceed \$200

### Activities of Committees

Constitution and Bylaws.-The Council acted on a set of bylaws sent by the County of Fulton for approval. Section 10 provides that candidates to be eligible for election to membership shall have practiced medicine in the County of Fulton or in the ad joining county which has no county medical society for at least one year exclusive of internal lo

This section was disapproved as it was felt that a man should be entitled to become a member of a medical society upon obtaining his licensure The balance of the proposed bylaws were approved with minor corrections

Convention Committee -- Dr Carlton E. Wertz

Chairman, made the following report

The 141st Annual Meeting of the Medical Society of the State of New York took place at Buffalo from May 5 through 9 1947 The Civic Memorial Auditorium was the headquarters.

Attendance

1 316 Members 254 Guests 401 Exhibitors 1 971 Total

Teaching Day A special teaching day program was arranged by the Committee on Public Health and Education, Dr O W H Mitchell Chairman for Tuesday, May 6 This was woll attended. Scientific Program Approximately 125 papers

were read. Both General Sessions were well at tended The joint meeting of the Section on Medicine and the Section on Surgery drew a large attend ance for the panel discussion on poptic ulcer round table discussion on cases of proven chest pathology in the Section on Radiology evoked a lively discussion. The Section on Anesthesia presented a symposium on the use of procedure intravenously the Section on Dermatology and Syphilology a panel discussion on syphilis the Section on Urology a symposium on bladder tumors. All of these proved of much interest.

Scientific Exhibits The space available for the scientific exhibits was larger than in provious years This allowed for a greater number of exhibits and more space for each one than in former years exhibits were well presented and well attended by

members and guests.

The Scientific Award Committee awarded a first prize a second prize and honorable mention in two classes clinical and scientific.

Technical Exhibits The Technical Exhibits were

also well attended

Banquet The Banquet and Annual Meeting at the Statler Hotel was attended by approximately 400 people. A feature of the banquet was the presentation of certificates to members of the Society who had been in practice for fifty years or more Seventy-one members were guests of the Society and took part in this ceremony

Woman's Auriliary The Woman's Auxiliary had rooms at the Statler Hotel for all their activities The ladies expressed pleasure at the facilities pro-

vided for them.

A role of thanks was extended to the Committee.

Dr Anderton reported that the Waldorf Astoria and the Pennsylvania Hotel had both been investigated with the idea of finding out which one would be the better to hold our 1948 Annual Meeting

After discussion.

It was roled to accept the offer of the Pennsylvania Hotel

Committee on Economics -Dr Werts Chairman referred to the following report of the Director of the

Bureau of Medical Care Insurance
April 4 1947 The Director attended a meeting of the Subcommittee on Medical Expense Insurance Dr A II Asron Chairman, at the Hotel Commo-dore New York City The Committee reviewed suggested standards of approval of New York State medical care plans by the Medical Society of the State of New York, and it was recommended they be brought before the Council through the Council Committee on Public Relations and Economics for approval The Council approved the standards which were later adopted by the House of Delegates at its Annual Moeting in Buffalo May 5 1947

April 8 1947 Mr Farrell addressed the Wo-

man's Auxiliary of the Medical Society of the County of Ulster at Kingston New York

April 16 1947 Mr Farrell met with Mr W A. Milliman, associate actuary and Dr Harry Unger leider, medical director of the Equitable Life Assur ance Society to discuss the exchange of statistical data regarding enrollment and benefits offered by the voluntary nonprofit and commercial plans.

April 22 1947 The Director appeared before the Erio County Medical Society and presented a report on the status of the Western New York Medical

Plan, Buffalo

1pnl 29, 1947 Mr Farrell addressed the Woman's Auxiliary of the Medical Society of the County of Groene, at Catskill

The week of May 5 to 9 1947 Mr Farrell attended the Annual Meeting of the Medical Society of the State of New York, at Buffalo At his aug gestion resolutions were introduced for approval by the Medical Society of the State of New York of the Northeastern New York Medical Service Inc. Al bany, Genesce Valley Medical Care Inc Roch-ceter and Central New York Medical Plan Syra

ouse Approval was granted by the House
A paper was presented by Mr Farrell, at a General Session on May 9 1947 entitled What the
Medical Care Plan Means to the Doctor and the

Public.

May 5 1947 On invitation of Dr Harvey Hoff man Mr Farrell spoke before the senior medical students of the University of Buffalo, behool of Medicine, on Voluntary Medical Care Plans. May 23, 1947 Mr Farrell attended the Regional

Conference of the Council on Medical Service of the American Medical Association in Pinladelphia

During the week of June 7 to 12 1947 the Director was present at the Annual Convention of the American Medical Association in Atlantic City

An informational pamphlet on the progress of New York State medical care plans, prepared for dis-tribution at the Society's Annual Meeting, has also been sent in quantity to the six voluntary plans in the State for further distribution to their participating physicians to better acquaint them with the voluntary nonprofit insurance movement throughout the State.

The report was accepted.

Finance Committee.-Dr Albert F R. Andresen, Chairman presented the revised budget for the latter half of 1947

It was voted that this budget be recommended to the Board of Trustees.

Committee on Office Administration and Policies. -The Committee submitted a report on routine matters, and is continuing its studies in regard to improving the management and policies of the running of the office

Committee on Public Health and Education -Dr O W H Mitchell, Chairman, reported as fol-

May 6, 1947 At the request of the New York State Department of Health, a joint meeting of the Council Committee on Public Health and Education and the Subcommittee on Cancer was held in Buffalo at the time of the Annual Meeting present at this session were some of the officers of the Medical Society of the State of New York and representatives of the State Department of Health and the American Cancer Society

The chief subject for discussion had to do with cancer detection clinics or service, and the conclusion was that the requirement for such an activity should he drawn up and submitted to us for consideration. This report has not as yet been received from the

State Health Department

June 6, 1947 In New York City a meeting of the Council Committee on Public Health and Education was held Present were some of the of-ficers of the Medical Society of the State of New York and representatives of the State Department This meeting was held to consider of Health the syphilis control program, (b) plasma and whole blood transfusion by nurses, (c) other matters
(a) Syphilis Control Program This will be

This will be changed due to the new methods of treatment, and will involve the distribution of penicillin to general practitioners, which will require a change in our educational program The director of the Division. Dr

Bloomfield, will submit his program to us

(b) Plasma and Whole Blood Transfusion by The question arose in one county about nurses being responsible for blood transfusions was agreed that a nurse could not possibly be re-

sponsible for that procedure
June 14, 1947 In New York City your Chairman attended a meeting of the Rheumatic Fever Advisory Committee of the New York State Department

of Health

Dr Swift, of New York City, is Chairman of this Committee, and we are trying to develop a program that will be satisfactory to the medical profession. This involves federal funds from the Children's Bureau, and it was agreed to by the Advisory Committee that when the program is developed, it is to be submitted to the Committees who are concerned

with this particular activity

Public Health Activities Dr Gordon D Hoople, Chairman of the Subcommittee on Hard of Hearing and the Deaf, read a paper on the conservation of hearing program in New York State in the Eye, Ear. Nose and Throat Section of the Medical Society of the State of New York. This paper outlined the pro-posed plan which the Committee is attempting to establish throughout the State It was well received, and, in addition, created newspaper comment throughout the State, particularly in the metropolitan dailies

Cancer The following paragraph appears in a recent communication received by the Chairman of the Council Committee on Public Health and Education from the director of the Service Division of the American Cancer Society, Charles S Cameron,

M D

"The American Cancer Society desires to distribute a copy of the postgraduate medical education course outline book to each of its divisions as a model for them to follow"

In compliance with this request, 50 copies of the 1946-1947 Course Outline Book were mailed to Dr Cameron

Postgraduate Instruction Postgraduate instruction has been completed in the following county Cortland, Fulton, Ma l, St Lawrence, Sar eca, Sullivan, Tioga, Madison, medical societies Nassau. Rockland, Saratoga, Schenectady, Seneca. Tompkins.

Instruction is being given in the following county medical Societies Cayuga, Oswego, and Warren

Arrangements have been completed for instruction to be presented in the fall in the following county medical societies Broome, Orange, and Oswego

Because we were so late in having the Course Outline Book printed last year, only a supplement will be distributed for 1947-1948 Letters have been Letters have been sent to those physicians who have arranged material for inclusion in the book requesting them to let us know of any changes desired in their announcements

The report was accepted

Committee on Public Relations -According to a recommendation approved by the Council April 10 and the House of Delegates May 6, the name of this Committee has been changed from the Council Committee on Medical Publicity to the Council Committee on Public Relations

News Releases concerning teaching days and other events sponsored by the Committee on Postgraduate Education were sent to the papers of 12 counties
These counties were Broome, Chemung, Cortland,
Madison, Nassau, Rockland, Schuyler, Steuben,
Sullivan, Tioga, Tompkins, and Ulster
Mr. Dwight Anderson, Mr. Edgar L. Cook, and
Mr. Thomas Walsh mot with Stets Separate Corey

Mr Thomas Walsh met with State Senator Corey Mills, who suggested that we prepare a brochure especially for use with the Legislature explaining the origins, functions, and activities of the State Medical Society He said the Legislature had no conception of the contributions that the State Medical Society makes to the health and welfare of the public and should be so informed This brochure is in prepara-

The award of 71 commemorative certificates for more than fifty years of the practice of medicine to member physicians of the Society featured the 141st Annual Meeting, May 5 to 9, in Buffalo hundred and sixty additional certificates were mailed to fifty-year practitioners throughout the State who were unable to attend the banquet

Lafe science researcher Geraldine Lux and photographer Werner Wolff covered the fifty-year doctor event. Nine news reporters covered the entire meeting, and two photographers covered various

events

Two press rooms were maintained, one at the Convention Hall during the day and one at the Hotel Statler after business hours

Mr Anderson and Mr Cook arranged with Mr Walter Law, of NBC, for Dr Morris Fishbein to make a recording concerning the A.M.A commemorative stamp which was used on a stamp radio pro-

gram from 9 45 to 10 00 A.M on Saturday, June 7
Mr Anderson, Mr Walsh, and Mr Cook attended the A M A meeting June 9 to 13 in Atlantic

City

Mr Cook, Mr Walsh, and Mr Farrell assisted Dr Bauer and Dr McGoldrick in preparing a brief and supporting statistical documents for a Senate hearing on the National Health Bill, S 545, the Taft-Smith-Ball-Donnell Bill, June 5, at which Dr McGoldrick and Dr Winslow testified before the Senate Committee on Labor and Public Welfare

The report was accepted Publication Committee

Increase in the Subscription Price of the Journal The Committee submitted a report showing that the Journal would continue to show a deficit on cash subscriptions if the price to nonmembers was not in creased.

It was roled that subscription rates to nonmembers be \$5.00, and that the allocation from members dues be \$2 50 to go into effect November I 1947

Future Issues of the Journal Gradually with new facilities being made available in the printing plant the Journal should reach members at the approxi mate date announced on the cover. In view of the increased circulation due to a larger membership the restricted allotment of paper has resulted in a smaller individual journal but there is a prospect of a more satisfactory supply of paper this fall. It will be necessary to omit certain sections during the summer in order to advance the publication of the many man uscripts now in our files including those from the annual meeting. The hoped-for improvement in the makeup of your journal must be deferred until the paper shortage can be overcome The report was accepted

Woman's Auxillary -Dr Beckman Chairman of the Advisory Committee to the Woman's Auxiliary read a report, dated June 4 1947, from the retiring President Mrs. Madden in which she gave a resume of the expenses for the year and their allocation against the \$1 000 which was appropriated.

Committee on Workmen's Compensation —Dr

J Stanley Lenney Chairman reported Legislation The Governor signed the Condon Bill permitting voluntary hospitals to obtain a laboratory or bureau license in connection with x-ray examinations The value of this license is apparent when one takes into consideration the provisions of Section 13(a) "Nothing in this section shall be con strued as preventing the employment of a duly au thorized physician on a salary basis by an authorized compensation medical bureau or laborator;

Such laboratory or bureau may submit bills for services rendered by employed physicians. A num-ber of commercial laboratories exist and employ qualified roentgenologists on a salary basis. are rendered in the name of the laboratory giving the name of the qualified roentgenologist and are pay-

able to the laboratory

It, therefore would seem that a hospital employ ing a physician on a salary basis having obtained a laboratory or bureau license from the Workmen's Compensation Board, may render bills and collect for services performed by salaried roontgenologists.

It is important to review other provisions of the law which affect the rights of a hospital to render medical and surgical services in connection with the above amendment. Section 18-f of the Workmen e Compensation Law states unequivocably (1) fees for medical services shall be payable only to a phy sician or other lawfully qualified person permitted by Section 13-b of this chapter to render medical cars under this chapter Hospitals shall not be entitled to receive the reumeration paid to physicians on their staff for medical and surgical services. Section 13-d of the Workmen & Compensation Law. concerning the removal of physicians from lists of those authorized to render modical care prohibits a physician authorized under the Workmen's Compen sation Law from dividing, transferring assigning, rebating, splitting or refunding a fee for medical care and other medical services including x ray and laboratory examinations except that reasonable pay

ment not exceed 331/1 per cent of any fee received for x-ray examination, diagnosis or treatment may be made by a physician to the hospital furnishing fa cilities for x ray examination, diagnosis or treatment A similar provision exists in Section 1264 of the Education Law

Are these latter provisions in conflict with the amendment to the law which gives to voluntary hospitals the same right to practice roentgenology as was given to lay persons or corporations (Section 13(a)) in the original anendment of 1935 provided that these lay persons or corporations employ a duly authorized roentgenologist to supervise and operate the laboratory? It seemed to be the clear intent of the original law that only a physician could render medical and surgical service and be paid therefor The insertion of the provision in Section 13(a) au thorizing lay-owned x-ray laboratories was made after the original bill was introduced in 1935 and as a result of the intervention of pressure groups and particularly of a certain commercial inhoratory in New York City This nullified the beneficent provisions limiting medical and surgical service to duly qualified and authorized physicians. We protosted at that time refusing to recommend said commercial laborator, for lie using, but a license was nevertheless issued on appeal to the Industrial Council of the

Department of Labor

We are dealing with two antithetic concepts. The first enables lay-owned laboratories or hospitals to provide certain types of medical care such as x-ray and laboratory services and to be paid therefor. The second concept is that these services being medical care can only be rendered by a physician under the law in accordance with our cone pt of the practice of medicine. We can only anforce our view point and seek remedial legislation to clear up these ambiguities if we can show and prove that x-ray and other services like anosthesia pathology and physical medicine are the practice of medicine At present we are not on safe legal ground in as arting that The Court of radiology is the practice of medicine Appeals decision in the Sausser case is precedent for Until and unless this precedent the opposite view is removed either by court action or by substantive changes in the Medical Practice Act and in the Workmen's Compensation and Lducation Laws declaring that radiology and the other specialties are definitely the practice of medicine there is little chance of clearing up the am aguities and redun-dancies in the law which are so detrimental to the proper administration of the Workmen's Compensa tion Law and to the creation of harmonious and equitable relations between hospitals and the mediral profession.

We have gone one step in the right direction. We have an agreement with the Hospital Association to the effect that the four specialties mentioned are the practice of medicine If this agreement was written into the law as we have endeavored to do for a num ber of years, it would be easier than to amend the Workmen & Compensation Law to remove the ambiguittee above mentioned and then go on to creating a modus essends between hospitals and the specialists mentioned in regard to contracts salaries, and other matters which are today the subject of continued discussion and perplexity

We again draw to the attention of the Council the necessity of taking the fundamental step of amend ing both the Workmen's Compensation Law and the Education Law to include definitely these four specialties as the practice of medicine, as a first step Delay may be dangerous in impeding or halting the encroachment of hospitals in the practice of

Despite our disapproval and protests the bill to amend the Workmen's Compensation Law in relation to the review, revision, or revocation of a physician's authorization introduced in this session of the legislature was enacted into law. This revision amends subdivision 2 of Section 13-b of the Workmen's Compensation Law as follows

"The medical practice committee, or the medical society or the board designated by it, or the board as otherwise provided under this section, may from time to time review the qualifications of any physician as to the character of the medical care which such physician has theretofore been authorized to render under this chapter and may recommend to the chairman that such physician be authorized to render medical care thereafter of the character which such physician is then qualified to render On such advisory recommendation the chairman may review and after reasonable investigation may revise the authorization of a physician in respect to the character of medical care which he is authorized to render If the medical practice committee or the medical society or board recommends to the chairman that a physician be authorized to render medical care under this chapter of a character different from the character of medical care he has been heretofore authorized to render, such physician may appeal from such recommendation to the medical appeals unit of the industrial council "

It will be noted that either the Medical Practice Committee operating in the four New York Counties or the Medical Society Compensation Committee having jurisdiction elsewhere in the State may from time to time review qualifications given to a physician and recommend to the Chairman that his rating be changed ostensibly to conform to his then On such advisory recommendation qualifications the Chairman of the Workmen's Compensation Board may review and after reasonable investigation may revise the authorization of a physician

There is no provision either initially by the Medical Practice Committee or the Medical Society for requiring a hearing of the physician whose rating is to be changed or revised However, the Chairman of the Workmen's Compensation Board after receiving merely advisory recommendation need only investigate and not afford the physician a hearing If after acting on the recommendation of the Medical Practice Committee or the Medical Society, the Chairman of the Board gives the physician a rating changing the character of the medical care he was originally authorized to render, the physician has the right of appeal to the Medical Appeals Unit of the Industrial Council

It is presumed that the amendment applies only to a reduction in the scope, range, or authorization of the physician to render medical care, since if his rating were changed to include a greater range, as now already provided for in the law, there would be no need for an appeal So it can be taken for granted that the amendment was introduced to permit the Chairman of the Board to change the ratings of specialists and qualified physicians for one reason or another, the precise reasons not being given in the

Our protests and disapproval of this amendment were based principally on the fact that a physician has no right to a hearing either before the Medical Society or the Medical Practice Committee before his rating is changed. The physician is thus deprived of an important and valuable right once given him after due process without an opportunity to de-It is to be presumed that the fend his position Chairman of the Workmen's Compensation Board although she is not required to hold a hearing, will make such investigation as she deems proper Chairman is, however, not required to hold a formal

Then an appeal may be taken to the Medical Ap-

peals Unit of the Industrial Council

Let us, therefore, investigate the authority of the Industrial Council under the present law The decision and recommendation of the Medical Appeals Unit of the Industrial Council shall be advisory only to the Chairman and shall not be binding or conclu-Under the provisions of the original sive upon him amendment to the Workmen's Compensation Law, setting up the Industrial Council, the decision of the Medical Appeals Unit in all matters within their jurisdiction was final, binding, and conclusive upon the Industrial Commissioner When the workmen's compensation division was separated from the office of the Industrial Commissioner and a Workmen's Compensation Board and a Chairman thereof set up in 1944, it was provided that the findings of the Medical Appeals Unit of the Industrial Council would only be advisory to the Chairman of the Workmen's Compensation Board Therefore, a physician taking an appeal over the findings of the Chairman of the Workmen's Compensation Board changing his rating and depriving him of certain privileges and property rights, actually is at the mercy of the Chairman of the Board Is it likely that once having gone so far as to make a finding in regard to the physician's qualifications based upon her investigation, the Chairman will be influenced by a body which has only advisory power and whose findings are not, as they should be, binding and conclusive upon her? It is as though a person being aggrieved at a verdict of a judge or jury of the lower court, and having the right of appeal to a higher court, finds that the decision of the appeals court is only advisory to and not conclusive upon the lower court. We believe this to be contrary to good practice and unjust This amendment should not be permitted to remain on the statute books as it deprives a physician of his day in court both initially and on appeal It is dictatorial, inequitable, and unjust, and deserves the scrious consideration of the Council

The Council should take into consideration the advisability of increasing the size of the Workmen's Compensation Committee Since Council committees are limited to three, it would be necessary to appoint an advisory committee of, say, three members, making the committee six in number various sections of the State should be represented on this Committee It is important that members appointed to this committee have a genuine interest in and understanding of workmen's compensation problems if they are to be of any service to the committee in the consideration of the numerous mat-

ters that are constantly before it

Dr Kenney continued his report by stating that at the April 10, 1947, meeting of the Council, a resolution presented by the Medical Society of the County of Albany had been read for the information of the Council The gist of this resolution was that the members of the Albany County Society were going to charge fees above the minimum schedule, and arbitrate when necessary Also a letter was sent and arbitrate when necessary Also a letter was sent to Mr Martin on May 20 from the Onondaga County Medical Society requesting an opinion on the legality of such procedure Since that meeting we have had the announcement to the House of Delegates of the proposed increase in fees.

After discussion

It was roted that the Council of the Medical Society of the State of New York go on record that it would disapprove of any county society taking any action to bring cases to arbitration under the Workmen's Compensation Law except such cases as those in which unusual service was rendered inasmuch as negotiations for changing the existing minimum fee schedule are in progress

Committee Appointments.-Dr Bauer presented the following list of committee appointments which

were approved by the Council

It was roted that the President be empowered to appoint another Subcommittee to assist the Legislative Committee, designation to be made after consultation with Dr. Aranow and Dr. Mitchell. It was roted that the nomination of Session Of

ficers be postponed until a future date.

Gerlatrics.—Dr Bauer read a letter from Dr C Ward Crampton under date of June 4 1917 suggest ing that organized medicine take the leadership in the field of geriatrics and that the State Society ap-

point a committee or subcommittee to put the mat

ter forward in the medical field It was voted that this be referred to the Committee on Public Health and Education for a study

Council Committees for 1947-1948

Constitution and Bplaces

James R. Reulling, 217-07 40th Avenue Bayside, Chairman
George W. Moemak, 23 East 93rd Street, New York

W. P. Anderton 292 Madison Avenue New York

serentiaes and the series of t

(Another member to be appointed) cientifis Awards (Subcommittee) (Committee to be appointed)

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Medical Society of the State of Vew York
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Chairman
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Medical Expense Insurence (Subcommittee)

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Leo F. Simpson, 201 Alexander Street, Rochester

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Foo C. Giben, 300 Medical Aris Building Syranuse

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C, Otto Lindbock, 100 E. Fourth Street, Jamestown

Abraham Koplowitz, 1401 President Street Brooklyn

Alliton J. Goodfriand, 1833 Grand Concourse, Bronx

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Carlion E. Wertz, 91 Parker Avenue Buffalo

Carlion E. Wertz, 91 Parker Avenue Buffalo

Charles F. Rourke, 003 MicCallen Street, Schenectady

Roward P. Webb, 264 O nesses Street, Utox.

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Brooklyn
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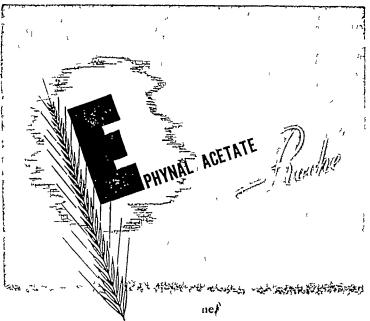
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[Continued on page 1920]



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Leo F Schiff 46 Cornelia Street, Plattsburg 1949 term expires Gordon Heyd 116 East 53rd Street New York 1950 term expires
John F Kelley 258 Genesee Street Utica 1951 term

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O W H Mitchell 428 Greenwood Place Syracuse
Albert F R Andresen, 88 Sixth Avenue, Brooklyn

Prize Essays Chas Gordon Heyd 116 East 53rd Street, New York, Chairman Armitage Whitman 77 Park Avenue New York

#### MINUTES OF THE HOUSE OF DELEGATES

Continued from page 19081

of laboratory medicine in the hospitals, placing such practice on the same broad by as now governs the relationship of medica. with the institutions of this state, and that mittee be appointed by the President with the approval of the Council to carry out this study"

Splaker Andresen Referred to the Reference Committee on New Business B, of which Dr Frederick W Williams is the Chairman

Section 50 (See 110)

#### Care of the Chronically Ill

DR EDWIN L HARMON, Westchester This concerns the care of the chronically ill

"Whereas, statistics show that we have an aging population and therefore that the problems of geriatrics must receive greater consideration in future planning, and
"Whereas, studies have indicated that stand-

ards of care for the chronically ill in private nursing homes, now caring for many of the aged, are inadequate and for the most part very costly, and "Whereas, the Governor's State Health Pre-

paredness Commission has recognized this need and has recommended the establishment of several small teaching hospitals for the treatment of the chromically ill to be scattered throughout the state, and

"Whereas, these hospitals cannot meet the present need but will serve as demonstration projects, now, therefore, be it

"Resolved, that the Medical Society of the State of New York should interpret this need to the physicians and the public and should urge that the construction of separate buildings or special wings for the care of the chronically ill be included in the building programs of voluntary general hospitals throughout the state "

Referred to the Reference SPEAKER ANDRESEN Committee on Report of the Council, Part VI, of which Dr Edward P Flood is Chairman

Are there any further resolutions? There was no response

There being no further SPEAKER ANDRESEN resolutions that anyone wishes to introduce at the present, I want to appeal to you again to get over to the reference committee meetings and argue things out over there first instead of doing it on the floor of the House

Section 51 (See 4)

#### Change in Reference Committee Appointment

I wish to announce a SPEAKER ANDRESEN change in the Reference Committee on New Business B There will be a new member, Dr Alfred M Hellman, of New York, to replace Dr Harold B Davidson, who is not here

The House will be in recess until 9 o'clock tomorrow morning

At 1 PM a recess was taken, until Tucsday, May 6, 1947, at 9 00 A M



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#### MEDICAL NEWS

#### American College of Surgeons to Hold Clinical Congress in New York September 8-12

THE thirty-third annual Clinical Congress of the American College of Surgeons, including the twenty-sixth annual Hospital Standardization Conference, will be held at the Waldorf-Astoria, New York, from September 8 to 12 The five-day program features operative and nonoperative clinics in 38 hospitals in New York and Brooklyn, and scientific sessions in general surgery and the surgical specialties, official meetings, hospital conferences, medical motion pictures, and educational and technical exhibits, at the headquarters hotel

Dr Howard A Patterson, of New York, is chairman of the Committee on Arrangements, Dr Frank Glenn is secretary Dr Malcolm T Mac-Eachern and Dr Bowman C Crowell, Chicago, the associate directors, are in general charge

The Convocation, at which between five and six hundred initiates will be received into fellowship, will be held on Friday evening, September 12 The new president, Dr Arthur W Allen, will confer the fellow ships and honorary fellowships Dr Andrew C Ivy, of Chicago, will give the Fellowship Address The new

#### Academy to Hold Twentieth Graduate Fortnight in October

THE New York Academy of Medicine, 2 East 103rd Street, New York City, has announced that the twentieth graduate fortnight will be held October 6 to 17 The subject to be discussed is disorders of metabolism and the endocrine glands The program includes morning panel discussions, afternoon clinics, evening lectures, scientific exhibits, and demonstrations

Dr George Baehr, president of the Academy, will give the opening address on October 6 his talk, the Ludwig Kast Lecture will be presented by Dr Hans Selve, of the Institute of Experimental Medicine and Surgery, University of Montreal, and the Carpenter Lecture will be given by Dr John S L Browne, of McGill University Clinic of the Royal Victoria Hospital in Montreal. Dr Selye will speak on "The Diseases of Adaptation with Main Emphasis Upon Hypertension," and Dr Browne's lecture is entitled "The Adaptation Syndrome in Man.

The evening lectures are as follows October 7, "Energy Metabolism in Obese Persons," by Dr Louis H Newburgh, University of Michigan Medical School, and "Psychological Aspects of Obesity," by Dr Hilde Bruch, College of Physicians and Surgeons, Columbia University, October 8, "The Relation of the Adrenals to Immunity," by Dr Abraham White, of Yale University, and "Clinical Experimental Studies on Adrenal Cortical Hyperoctober 9, "The Metabolic Consequences of Immobilization," by Dr John E Deitrick, Cornell University Medical College, and "The Use of Androgens in Women," by Dr Ephraim Shorr, also of Cornell, October 10, "Studies in Intermediary Metabolism Conducted with the Aid of Isotopic Tracers," by DeWitt Stetten, Jr., Harvard University

Medical School, and "The Exerction of Urinary Steroids in Health and in Disease," by Dr Konrad Dobriner, Sloan-Kettering Institute for Cancer Research

"Disturbances in Electrolyte Metabolism in Man and Their Management," by Dr Daniel C Darrow, Yale University School of Medicine, and "The Role of Amino Acids in Nutrition," by Dr William C Rose, of the University of Illinois, will begin the second week on Monday, October 13 The remainsecond week on Monday, October 13

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ng lectures are
October 14, "Metabolic Functions in Old Age,"
by Dr Nathan Shock, US Public Health Service, Baltimore City Hospital, and "The General Aspects of Cushing's Syndrome," by Dr E C Reifenstein, Jr, Sloan-Kettering Institute for Cancer Research of the Memorial Hospital Cancer Centre, October 15, "Hormonal and Chemical Factors Regulating Thyroid Function," by Dr Rulon W Rawson, Harvard Medical School, and "Some Chinical Experiments with Antithyroid Compounds," by Dr Edwin B Astwood, of the Joseph H Pratt Diagnostic Hospital, Boston, October 16, "Testicular Dysfunction, Some Clinical, Aspects," by Dr E Perry McCullagh, Cleveland Clinic, Cleveland, and "The Use of Androgens in Men," by Dr Carl G Heller, University of Oregon Medical School, and on October 18, "Why Do Women Abort," by Dr Arthur T Hertig, Harvard Medical School, and "Morphological Basis for Menstrual Bleeding," by Dr Joseph E Markee, of Duke University Medical School
The registration fee is \$5.00. A program will be

Markee, of Duke University Medical School The registration fee is \$5.00 A program ne registration fee is \$5.00 A program will be mailed to each Fellow of the Academy without request and to other. request and to other physicians upon request Requests should be addressed to Dr Mahlon Ashford, 2 East 103rd Street, New York 29

#### Second Annual Postgraduate Course in Diseases of the Chest

THE American College of Chest Physicians is sponsoring a second annual postgraduate course in diseases of the chest to be held during the week of September 15 to 20, 1947, at the Municipal Tuberculosis Sanitarium, Chicago, Illinois
The emphasis in this course will be placed on the

newer developments in all aspects of diagnosis and treatment of diseases of the chest

The course will be limited to 30 physicians Further information may be secured at the office of the American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

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a cough

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to stop

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A few inhalations by mouth control cough quickly

[Continued from page 1922]

#### Whitney Foundation for Rheumatic Fever Study

THE Helen Hay Whitney Foundation for Rheumatic Fever Research was opened on July 7 Dr T Duckett Jones, who is on leave from the House of the Good Samaritan in Boston, is medical director of research activities

The purpose of the foundation, which will have temporary offices at New York Hospital, is to stimulate and help finance basic research which may throw more light on the cause of rheumatic heart fever

Creation of the new foundation was announced by a distributing committee which included Mrs Charles Payson, John Hay Whitney, Frederick H Trask, Jr, and William Harding Jackson

#### **PERSONALITIES**

Dr George J Zippin, of Schenectady has opened his office in Schenectady, limiting his practice to the treatment of diseases of the skin

Dr Zippin served four and a half years in the armed forces. He was chief of the dermatology section of the 224th General Hospital which served in the United States, European, and Pacific theaters. He is a diplomate of the American Board of Dermatology and Syphilology.

Assignment of three New York doctors as commanding officers of three organized reserve medical groups in New York was announced in June by Gen Courtney H. Hodges, head of the First Army

Col Joseph Haas, of New York City, will command the 139th Organized Reserve Medical Group, Manhattan. Col Herman Reinstein, of Brooklyn, has been chosen as commanding officer of the 146th Organized Reserve Medical Group, Brooklyn Col James H Kidder, of the Bronx, will head the 154th Organized Reserve Medical Group in the Bronx

Dr Frederick E Squires, of Livonia, celebrated his eighty-second birthday on August 17 and his fifty-first year of professional service in that community Dr Squires was among the group of New York doctors who were awarded certificates by the Medical Society of the State of New York in recognition of fifty years of medical practice at the Society's Annual Meeting in May

Dr Squires was born in Churchville, New York, August 17, 1865, and after being graduated from Cazenovia Seminary, he entered the University of Buffalo, School of Medicine He interned at Buffalo General Hospital, and later did postgraduate work at the New York Lying-In Hospital, New York Post-Graduate School, and the Massachusetts General Hospital For twelve years he was health officer of Livonia

During the half century of his practice, Dr Squires recalls two serious epidemics, one of typhoid in 1897, and the flu epidemic in 1918. During the latter epidemic, in one day he made 96 calls. Dr Squires estimates that he has assisted at approximately 1,500 births.

He is in excellent health and continues to be active in his practice

Dr Oswald R Jones, of New York, was appointed in July by Governor Thomas E Dewey to a fiveyear term as chairman of the new State Tuberculosis Committee

The Governor also appointed four other physicians on the five-member committee, which will act in an advisory capacity to the State Health Commissioner They were Dr Edward M Packard, Saranac Lake, four years, Dr John E Mosely, New York, three years, Dr James R Reuling, Bayside, Queens, two years, and Dr William McCann, Rochester, one year

Dr Byron D St John, of Port Washington, New York, has returned to the practice of medicine after an absence of six months, due to illness

Dr Anthony Bassler, New York City, received first prize in oil paintings for his "River Styx" at the Atlantic City meeting of the American Physicians Art Association He also won first prize in humorous poems and permanent possession of the Secretarie's cup at the Physician's Literary Guild

Dr James W Smith, of New York City, read a paper on "Ophthalmologic Office Procedure" before the Reading, Pennsylvania, Eye, Ear, Nose and Throat Society on June 18, 1947

Dr Louis S Goldstein, of Yonkers, New York, who for fifteen years has been associated with the Childhood Tuberculosis Clinic at the Vanderbilt Clinic, recently was elected to membership in the American Academy of Tuberculosis Physicians and the Medical Section of the American Trudeau Society

The Maimonides citation for "outstanding scientific scholarly achievement" recently was awarded to Dr Israel S Wechsler, of New York City, by the Jewish Theological Seminary of America, New York City

[Continued on page 1926]

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# POSTGRADUATE MEDICAL EDUCATION

Programs arranged by the Council Committee on Public Health and Education of the Medical Society of the State of New Yorl are published in this Section of the Journal. The members of the committee are Oliver W H Mitchell, M D, Chairman (428 Greenwood Place, Syracuse), George Bachr, M D, and Charles D Post, M D

Broome County Dr Franz Altmann, assistant clinical professor of otolaryngology at College of Physicians and Surgeons, Columbia University, will speak on "Memere's Syndrome and Related Conditions" at the Binghamton City Hospital on Tuesday evening, November 11, at 8 30 PM

Cayuga County "Medical Aspects and Hazards of Controlled Nuclear Energy" will be the subject of instruction to be given by Dr William F Bale, associate professor of radiology at the University of Rochester School of Medicine and Dentistry, at the Osborne Hotel in Auburn on Tuesday evening, September 18, at 8 30 P M

Cortland County Dr Carl H Greene, clinical professor of medicine, Long Island College of Medicine, will speak on the subject of "Nephritis" on September 19 On October 17 Dr William Dock, professor of medicine, Long Island College of Medicine, will have a his subject, "Peptic Ulcer and Gastric Cancer '

These postgraduate instructions will be given on Friday evenings at 8 30 PM at the Cortland County Hospital

Orange County "The Diagnosis and Treatment of Anemia" will be the subject of Dr Paul Reznikoff "The Diagnosis and Treatment associate professor of clinical medicine, Cornell University Medical College, on September 9 Kurt Lange, assistant clinical professor of medicine, New York Medical College, will speak on "Peripheral Vascular Diseases" on September 30 On November 11 Dr Edward F Hartung, assistant clinical professor of medicine, College of Physicians and Surgeons, Columbia University, and chief of the Division of Arthritis, New York Post-Graduate Medical School and Hospital, will discuss "Diagnosis and Treatment of Low Back Pain from the General Practitioner's Point of View"

This series of instruction will be given on Tuesday evenings at 8 30 PM at the Orange County Court

House in Goshen

#### MEDICAL NEWS

[Con.inued from page 1924]

#### County News

#### Chemung County

Dr David J Kaliski, director of the Workmen's Compensation Bureau of the Medical Society of the State of New York, will be the moderator at a Round Table Discussion on Workmen's Compensation matters to be held by the Chemung County Medical Society on Wednesday, September 17

#### **Essex County**

The summer meeting of the Medical Society of the County of Essex took place at Elizabethtown, New York A dinner meeting was held at which 27 doctors and their wives attended

The speaker of the evening was Dr T J Cummins, chief surgeon at the Republic Steel Hospital, Mineville, New York He discussed silicosis and the use of aluminum inhalation in the treatment of silicosis

#### Madi.on County

Medical aspects of the atomic bomb were discussed by Dr Joe W Howland, instructor in medi-cine, University of Rochester School of Medicine and Dentistry, and formerly a major in the medical corps and chief of medical research, Medical Division, Manhattan Engineering District, on July 23 before members of the Madison County Medical Society

#### Nassau County

The next meeting of the Medical Society of the County of Nassau will be held on September 30

#### Oswego County

The Oswego County Medical Society members attended a lecture on June 17 given by Dr George P Heckel Dr Heckel, assistant professor of obstetrics and gynecology, University of Rochester School of Medicine and Dentistry, Rochester, New York, spale on the practical professor of the York, spoke on the practical applications of eudocrines in gynecology

#### Suffolk County

Postgraduate instruction arranged by the Council Committee on Public Health and Education of the Medical Society of the State of New York was held for the Suffolk County Medical Society on July 30

A lecture was presented by Dr J William Hinton, clinical professor of surgery, College of Physicians and Surgeons, Columbia University, and associate professor of surgery, New York University, on the surgical treatment of hypertension

#### Warren County

On June 26 members of the Warren County Medical Society attended a course in postgraduate instruction given by Dr Leo E Gibson Dr Gibson, professor of clinical surgery, Syrneuse University, College of Medicine, discussed the infections of the genitourinary tract

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#### HOSPITAL NEWS

#### American Hospital Association to Convene in September

THE forty-muth annual convention of the American Hospital Association will be held Monday, September 22, through Thursday, September 25, in St Louis, Missouri
"Major Factors Affecting the Hospital Economy"

will be the subject for the opening general session Monday afternoon Speakers will include John H Hayes, of New York City, Association president, R. O D Hopkins, New York City, executive director of the United Hospital Fund of New York, Alvin E Dodd, New York City, president of the American Management Association, and Leon H Keyserling, Was President Truman Washington, economic adviser to

Other sessions of the convention will be broken into four sections on professional practice, administrative practice, hospital planning and plant operation, and special aspects of hospital administration Thursday afternoon's final general session will consist of a résumé of the discussions in all of the special sessions under the topic, "American Hospitals Today"

The convention will conclude Thursday evening

with a banquet and ball

Outstanding hospital administrators and experts from related fields will give the principal talks at the convention, with panel discussions and audienceparticipation discussions to complete each meeting

#### Refresher Course in Medicine at City Hospital

'ITY HOSPITAL, New York City, announces that the next refresher course will be given from October 6 to November 7, 1947 The hours are 9 to 12 AM on Monday, Wednesday, and Friday, and 2 to 4 PM on Tuesday and Thursday Classes are held at the Welfare Island Dispensary

The course is a comprehensive review in internal medicine and the allied specialties designed to meet the needs of the general practitioner and the medical Emphasis is placed throughout on the veteran

diagnosis and treatment of the disorders commonly encountered in general practice The newer diagnostic and therapeutic procedures are described and evaluated in the light of clinical experience. Students are also permitted to make rounds on the wards of City Hospital by special arrangement.

There is no tuition fee. Request for applications.

should be addressed to Dr Milton B Rosenblatt, Welfare Island Dispensary, 80 Street and East End Avenue, New York 21, New York.

#### News Notes

Establishing a new record, the New York Hospital provided care for 72,271 patients last year, the Society of the New York Hospital announced re-

cently in its 1946 annual report

Covering the hospital's 175th year of service, the report shows the city's oldest hospital provided hospitalization for 24,324 patients in the private, semiprivate, and ward services, an increase of 1,843 over the previous year, and 47,947 patients received medical attention through clinic and other facilities available to ambulatory patients, an increase of 4,281 over 1945

A large number of returning veterans enabled the hospital to staff adequately the many services and clinics However, the opening of new beds was held up due to the shortage of nurses These new beds eventually will raise the total number to 1,532 including those at the New York Hospital-Westchester Division, the psychiatric hospital maintained by the

society at White Plains

The first professorship in cancer in any medical school has been established at the Cornell University Medical College With an annual endowment of \$15,000 for five years, it represents the first allocation of funds from the 1947 campaign of the New York City Committee of the American Cancer Society

civilian general hospital in this country, have been formally opened at Bellevue Hospital by Mayor O'Dwyer They are patterned after the rehabilitation services of the Army and Navy, and the facility was described by Dr Edward M Bernecker, New York City Commissioner of Hospitals, as "medical history in the making"

Columbia University has joined the Institute r the Crippled and Disabled in an operating affiliation to train physicians, nurses, technicians, and social workers for a large-scale program for rehabilitation and re-education of the disabled, it was announced by Dr Frank D Fackenthal, acting director of Columbia, and Walter Ewing Hope, president of the Institute

Because of a steadily increasing demand on facilities, St Luke's Hospital, New York City, must expand and improve its services, according to the hospital's eighty-eighth annual report A total of \$7,500,000 is needed for the planned expansion

Lincoln Cromwell, president of the hospital, cited a demand for more space in the outpatient department, additional clinics, an obstetrical service, a diagnostic clinic, clinical and research laboratories, and more extensive accommodations for private and semiprivate patients He said it was

Two new rehabilitation wards, the first in any

[Continued on page 1930]

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[Continued from page 1928]

necessary also to modernize the older buildings and to acquire new and up-to-date equipment

St Luke's Hospital has recently become affiliated with Columbia University for the teaching of medical students

During the past year 26,105 patients were served by the Hospital for Joint Diseases, New York City, and its country branch in Far Rockaway, according to the fortieth annual report, recently released by Frederick Brown, president of the hospital The number included 5,872 bed patients and 20,233 ambulatory patients The hospital beds were fully occupied, Mr Brown said, and on the average day during the entire year there have been 200 bed patients waiting to be admitted to the hospital.

The Hospital for Joint Diseases added a new service, the Cancer Prevention and Detection Center, in June of 1946, and late in 1945 established a School of Practical Nursing, with a one-year course of training, which has already eased the nursing shortage in the hospital

A children's adjustment clinic to handle behavior problems of children and parents, will be opened soon at the out-patient department of Beth David Hospital, New York City Dr Ernest Harms, editor of the journal, The Nervous Child and Handbook of Child Guidance, has been appointed director of the new clinic

#### At the Helm

Appointment of Dr Marion B Sulzberger as director of the department of dermatology and syphilology of the New York Skin and Cancer Unit, New York City, and professor of clinical dermatology and syphilology of the New York Post-Graduate Medical School, was announced in July He succeeds Dr George Miller MacKee, who is retiring and has been named professor emeritus of the medical school

Dr Robert F Loeb has been appointed Bard professor of medicine and executive officer of the Department of Medicine at the College of Physicians and Surgeons of Columbia University and Director of the Medical Service at Presbyterian Hospital

Dr Loeb succeeded Dr Walter W Palmer, who had occupied the post since 1921, and who is now professor emeritus of medicine at Columbia University and a consultant of the Presbyterian

Hospital

Dr Loeb, who received his medical degree from Harvard in 1919, served on the staffs of the Massachusetts General Hospital and the Johns Hopkins Hospital and later joined the Presbyterian Hospital, becoming an instructor in the College of Physicians and Surgeons During the war Dr Loeb served as consultant to the Office of Scientific Research and Development and as chairman of the Board for the Co-ordination of Malarial Studies Recently he served as chairman of the Board of Review of the United States Atomic Energy Commission

Dr Leon Ginzburg has been appointed director of surgery at the Beth Israel Hospital, New York City He will assume this post on October 1

City He will assume this post on October 1
A native New Yorker, Dr Ginzburg was graduated from the College of Physicians and Surgeons, Columbia University, in 1920, and continued his education abroad under an Emanuel Libman Fellowship in surgery and pathology During the war, Dr Ginzburg served as assistant chief of the surgical service of the Third General Hospital, and as chief of the surgical service of the 235th General Hospital and the 25th General Hospital of the US Army

Dr Altred J Vignec, medical director and

pediatrician-in-chief of the New York Foundling Hospital, has been appointed director of pediatries at St Vincent's Hospital, New York City

Dr Burton L Zohman, of Brooklyn, has been elected attending physician on the Long Island College Division of the Kings County Hospital in Brooklyn, and was appointed associate professor of clinical medicine at the Long Island College of Medicine

Dr Irwin Philip Sobel, associate pediatrician at the Lenox Hill Hospital, New York City, has been appointed assistant clinical professor of pediatrics at the New York University, College of Medicine.

Dr Edmund Prince Fowler, Jr, succeeds Dr John Devereux Kernan as professor of otolaryngology and director of the ear, nose, and throat service at the Columbia-Presbyterian Medical Center He was a member of the Presbyterian's Second General Hospital Unit during the recent war and was a special consultant in ear, nose, and throat to the Air Surgeon

A graduate of Dartmouth, Dr Fowler received his medical degree as well as a medical science degree at the College of Physicians and Surgeons, New York. His internships were served at Presbyterian Hospital, where he has been assistant attending otolaryngologist since 1938. He is editor of the loose-leaf textbook, Medicine of the Ear. He is president of the Audiology Foundation, a member of the Committee on Hearing of the National Research Council, a fellow of the American Otological Society, and a member of other general and specialized societies including the International Collegium Otolaryngologicum

Dr Harold A. Abramson, assistant professor of physiology at the College of Physicians and Surgeons, Columbia University, and associate physician for allergy, the Mount Sinai Hospital, New York City, has been appointed active consulting physician for allergy at the Seaview Hospital, Staten Island.

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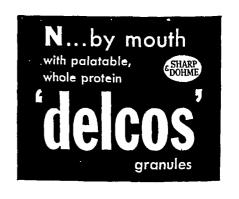
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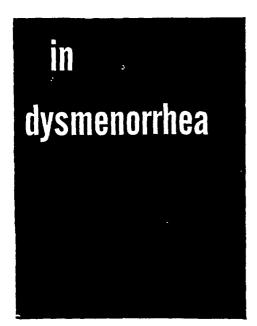
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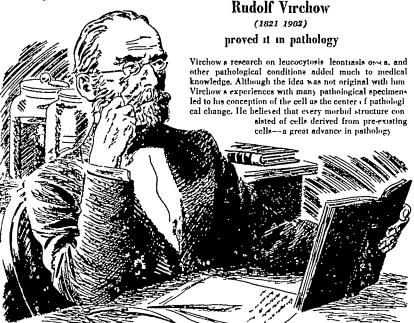
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VOLUME 47

**SEPTEMBER 15, 1947** 

NUMBER 18

Published twice a month by the Medical Society of the State of New York. Publication Office 20th and Northampton Sts, Easton, Pa Editorial and Circulation Office 292 Madison Ave, New York 17, N Y Change of Address Notice Should State Whether or Not Change is Permanent and Should Include the Old Address Twenty-five cents per copy—\$2.00 per year Entered as second-class matter March 13, 1939, at the Post Office at Easton, Pa, under the Act of August 24, 1912

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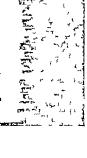
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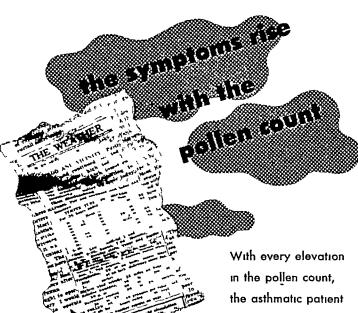
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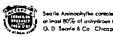
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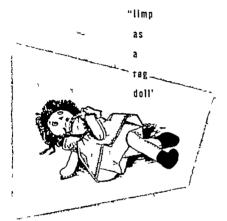


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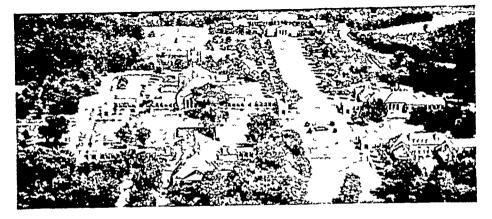
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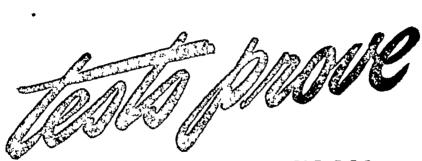
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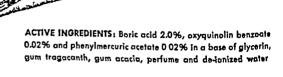
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Ferrolivron B (Harmon Chemicals, Inc.)		Strained Meats (Swift & Company) 3rd	cover
Globin Insulin (Burroughs Wellcome & Co)	$2035 \\ 2025$	Medical & Surgical Equipment	
	2020		*005
Glycerite of Hydrogen Perovide (International Pharmaceutical Corporation)	1936	Artificial Eyes (Fried & Kohler, Inc.)	1935
		Artificial Limbs (J E Hanger)	2037
Hepacoids (Gold Leaf Pharmacal Co, Inc) Kondremul (The E L Patch Company)	2031	Hydrogalvanic Generators (Leca Corporation)	2043
	1952	Orthopedic Shoes (Pediforme Shoe Co)	1944
Koromea (Holland-Rantos Company, Inc.)	1950	Supports (S. H. Camp & Company)	1966
Liquiderm (Colin Pharmacal Co)	2042	Supports (Wm S Rice Inc)	1956
Lutocylin & Lutocylol (Ciba Pharmaceutical	1040	X-Ray Equipment (General Electric X-Ray	
Products, Inc.)	1949	Corporation)	1961
Mandelamine (Nepera Chemical Co, Inc)	1953	3.5 11	
Mesopin (Endo Products Inc.)	1957	Miscellaneous	
Multicebrin (Eli Lilly and Company)	1974	Brioschi (G Ceribelli & Co)	2035
Nitroscleran (E Tosse & Co)	2037	Cigarettes (R. J. Reynolds Tobacco Co.)	1937
Penicillin Aerosol (Premo Pharmaceutical	1000	Cosmetics (Ar-Ex Cosmetics, Inc.)	2039
Laboratories, Inc.)	1938	Spring Water (Saratoga Springs Authority)	1948

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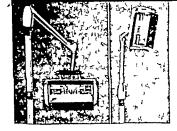
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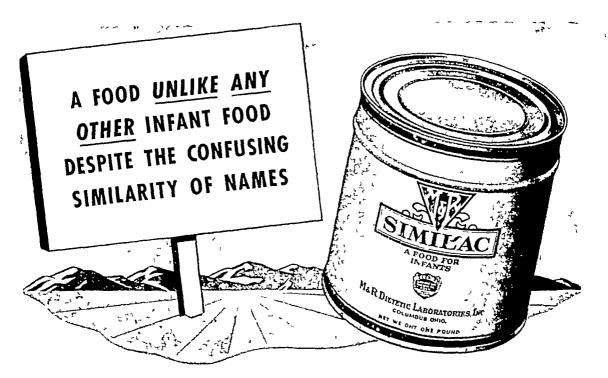
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  - 1 Barnes J: Brit. M J 179 (Jan.) 1944.

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- 2 Sikkema S. H and Sevringhaus, E. I. Am J. Med., 2 251 (March) 1947
- Finkler R S and Becker, S J A M W A., 1 152 (Aug.) 1946
   Finkler R S and Becker, S Am J Obst. & Gynec, 53,513 (March) 1917
- 5 Rakoff A E., et al Clinical Evaluation of Dienestrol A Synthetic Estropen I rescribed at Meeting of Assar for Study of Int Secretions Adaptic City N. L., June 6-7, 1917
- 6 Cordon F Value of Dionestrol in the Monopausal Syndrome (Tentstive Title) to be published



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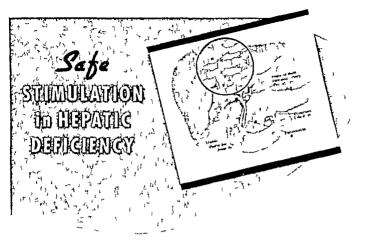
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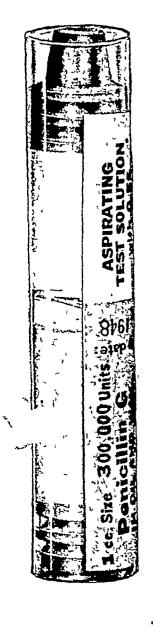
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VOLUME 47

SEPTEMBER 15, 1947

NUMBER 18

## Editorials

### What Your Taxes Buy in Washington

II

### Federal Health Workshops1

In a previous issue we discussed the propaganda device of the "Federal health workshops," sponsored by some six agencies of government for the purpose of creating an artificial, federally stimulated public demand upon Congress for enactment of compulsory health insurance <sup>2</sup>

Many doctors of medicine have had the uneasy feeling that some Federal departments, bureaus, and agencies were exceeding their proper functions, not openly perhaps, but in some way effectively, in forwarding such propaganda.

The device of the "health workshops" has not been disclosed previously, at least to our knowledge According to statistics from the report of the Committee on Expenditures in the Executive Departments, page 2, based on the latest figures from the Budget Bureau, "An increase of approximately 300 per cent in Federal expenditures for publicity and propaganda in a period of five years (1941 to

 This is the second in a series of editorials on this subject.
 House Report No 786 80th Congress, 1st Seeston, July 2 1947

1946) is deemed by your committee to be a proper subject for inquiry by the Congress." In that time expenditures for these purposes had increased from \$27,770,000, to \$75,000,-Was all of this increase in support of the legitimate activities of the departments bureaus, and agencies? Was the national program of "health workshops" launched by the Public Health Service under the "extraordinary executive pressure exerted upon to further the campaign for what certain witnesses and authors of propaganda referred to as socialized medicine a legitimate project for the U.S.P.H. in 1946? The Committee on Expenditures in the Executive Departments does not seem inclined to view it that way

Testimony before the committee indicates also that the staff and resources of the Bureau of Research Statistics in the Social Security Board were devoted freely, from time to time, to the preparation of pamphlets and propagands literature for the C.I.O the A.F.L., and the Physicians Forum.

the Social Security Board at Government expense, supported what certain witnesses and authors of propaganda refer to as socialized medicine in every approach and dismissed contemptuously all arguments controverting the fixed position of the Social Security Board (hearing, p. 170)

Your committee concludes from the testimony that most, if not all, of this literature, as distributed by the CIO, the AFL, the Farmers' Union, and the Physicians' Forum origmates in, and emanates from, the Bureau of Research and Statistics in the Social Security Roard

Mr Isadore Falk is director of the Division of Research and Statistics in the Social Security His principal assistant, Miss Margaret Klem, was a witness before your committee on Miss Klem was identified as chief of June 18 the Medical Economics Section of Mr Falk's She was one of the group of Federal Division employees who charted, arranged, and conducted the Jamestown Health Workshop testimony discloses also that she helped draft the Wagner-Murray-Dingell bill

Other evidence before the committee reveals that the Bureau of Research and Statistics of the Social Security Board also prepared pamphlets and propaganda material to be distributed under the imprint of the CIO Similar pamphlets were prepared in the same office for distribution as Government literature through the Department of Agriculture's Interbureau Committee on Postwar Programs All this matemal, as presented in our hearings, is similar in tone, content, and objective It all originates in one spot, in the Social Security Board It is all paid for, save the actual printing, by a process which your committee deems an improper use of Federal appropriations

Samples of all these pamphlets and propaganda leaflets are available in your committee's Photostatic copies of some of them have been transmitted to the Attorney General, with our request for action in defense of the American taxpayers, who are paying the bill

Little by little the linkages, the subterfuges, diversion of public funds for previously undisclosed propaganda purposes by agencies of government begin to show up The contention of many individual physicians, also their county, state, and national organizations, that persons within the government were utilizing these quite respectable departments, bureaus, and agencies to promote and foster a demand for socialized medicine which does not actually exist in the United States, seems to be justified shall have more to say on this subject

# Utopia

In a paper entitled, "Psychiatric Sense and Nonsense," Di C C Burlingame makes some interesting observations that deserve to be aired in even wider fields than those of psychiatry \*

A patient can be taken into a psychiatric institution and his psychiatric disorder can be alleviated by protecting him from the sin and suffering in the outside world and applying any one or several of other psychiatric treatments

I urge a period of self-analysis to see if the procedures used have not in a large measure been a desocialising influence For example. how many patients have been making baskets, weaving rugs, and polishing the floors in the hospital? How many of these same patients will make baskets, weave rugs, or polish floors in their communities if the psychiatrist succeeds in sending them home?

A psychiatrist must first of all be a good phy-

sician with a complete knowledge of the human body, and must use his knowledge in treating his Second, he must be a bit of a sociologist who is a constant student of the milieu in which his patient has lived and must live in the Third, he must be a psychologist who future understands the workings of the human mind Fourth, he must be a specialised type of educator, and fifth, he must be a vocational guidance ex-

It seems to us that Dr Burlingame has written a creditable description of a doctor His standards are difficult and exacting They presuppose that the education of such a man goes on all his life We can' hear many so-called "educated men" muttering "Have I got to go on studying all my life?" The answer is "Yes"—but not necessarily from textbooks And no doctor, we hope, ever undertook the practice of medicine in anticipation of an easy life

<sup>\*</sup> Burlingame C C J.A M.A 33 971 (April 5) 1947

Suppose we apply Dr Burlingame's principles to the field of industrial medicine, and, more specifically, to the problem of the injured working man. Everyone concerned in the problem—the patient, his doctor, the employer, the company doctor—is at fault in one way or another. The remarks that follow are not intended in the spirit of carping criticism, nor are they meant to wound any one's feelings. If they happen to do so, it will probably be because the cap fits.

Once the patient has adjusted himself to his invalidism and his reduced but certain income, he, at least subconsciously, may begin to think about how long he can stay sick. This is a danger inherent in workmen's compensation. One of man's greatest desires is for security, and once he gets it, he sometimes doesn't want to work. This is a fact evidently not very well understood by the leaders of Britain's Socialist party, with their slogan of "Security from the Womb to the Tomb"

The doctor, too, has a direct interest in prolonging the patient's convolescence would be interesting to speculate on how much harm has been done to the morale of all parties concerned by the invention of the diathermy machine It also enables the doctor to keep his patients under frequent supervision Surely this is desirable attending surgeon in a well run hospital service sees his patients every day, whether they need it or not In so-called "teaching institutions" the doctor likes to have his wards well-filled with fracture cases for the edification of his students. This has been largely responsible for the popularity of the treatment of fractures by traction and suspension

Employers also are at fault, though un derstandably so, because, with few exceptions, they will not take a man back to work until he declares himself capable of full duty on the job he held previously

Insurance companies, although with another goal in mind, too are at fault, for they try to hasten unduly the patient's convolescence. This leads to frequent and sharp differences of opinion between the patient's and the company's doctor. Ask any long-suffering "referee," or any "impartial specialist"

We can hear many of our readers breath-

ing heavily and muttering "What kind of a Utopia is this fool thinking about?" Well they have a right to know Criticism that offers no solution is fittle and permisons

First, we should like to be allowed to operate in a small industrial community Our experiment would be modeled along the lines of the Metropolitan Life Insurance Company's Framingham Experiment we could find it, we should choose one where relations between employers and employees were reasonably cordial Just think, if you can, of a town peopled by men of good We should have a mass meeting at which we should endeavor to explain the great but apparently incomprehensible doctrine that Labor is a mutual affair workman cannot work unless he has a factor, to work in, and a factory without workmen is a useless and expensive burden to its If it does not produce, the govern ment loses heavily on taxes And where will social security be then?

To return to the problem of the injured working man, the accident should not have occurred in the first place An accident is a black mark against all concerned. Once it has happened it is to the main interest of everyone concerned to restore the patient to working capacity as soon as possible are going to disregard the Simon Legrees of capital and the malingerers of labor are going to proceed upon a most unusual assumption-that both employer and em ployee have a little common sense ity, generally, is understood to be the greatest misfortune that can befall a man fore, the employer, backed by the insurance company, will procure the best possible medical and surgical attention tient will have his free choice of doctor, but every doctor in the community will know his business We mentioned Utopia once before didn't we?

As soon as it is humanly possible the patient will be returned to some kind of work Perhaps Dr Burlingame might allow the patient to engage in a little floor polishing for then he would have no chance for thinking of himself as an invalid. If he were in a hospital he would be among similarly injured men whom he knows. He would not be allowed to lie at home in lonely isolation, thinking of himself as the solitary victum of

misfortune He would not feel that the company doctor was trying to rook him of his just deserts

If it is clear that he will never be able to return to his original job, he would be taught another one If you don't believe us, we refer you to the Institute for Crippled and Disabled, 23rd Street and First Avenue, New York City

When he returns to work—any work—he will feel that he has been very well looked

after, and will feel kindly—no, we didn't say grateful—toward his employer. His boss will be glad to get him back so unexpectedly soon. The doctor will be pleased with the job he has done and the fee he has been paid, and the insurance company will have saved money.

Best of all, that community will have little call for the services of Dr Burlingame and his psychiatric colleagues

Utopia, it's wonderful!

### Current Editorial Comment

The Status of Abortus Infections in the United States Brucellosis masquerades under so many forms, invades so many tissues of the body, and is so protean in character, that the disease generally escapes diagnosis This is partly due to the fact that most cases in this country are Brucella abortus, attenuated to such a degree that the disease has lost its clinical identity

It is natural that the abortus variety should atta ingreater and more rapid attenuation than the suis or melitensis types, because of our almost universal use of milk and milk products in which the abortus organisms live. The extensive traffic in cattle and dairy products contributes to the spread and attenuation of the organism, and has made the clinical and laboratory diagnosis more difficult.

In his interesting article on abortus infections, presented at the Inter-American Congress for the Study of Brucellosis, in Mex-100 City last year, H J Schmidt gives some pertinent figures It is estimated that 6 to 10 per cent of all cattle excrete the organism, that 50 per cent of all milk-producing animals in the South are in herds infected with Brucella abortus, that 38 per cent of all dairy herds in the United States are infected, and that in 1911, 14 per cent of all market milk contained Brucella abortus acute brucellosis has probably declined, it is estimated that about 10 per cent of the population of the United States has become infected and that, at any given time, 1 per cent of those infected are ill with brucellosis

The same changes toward chronic infection, with attenuation of the organism as

observed in man, have taken place also in cattle. In recent years there has been a marked diminution in the incidence of abortion and dead fetuses among cows. In a southern rural region a survey showed 20 per cent of the cattle reacted positively for Bang's disease and, in some dairy herds, the incidence has been as high as 60 per cent. Only the finest stock were the reactors, the poorer diseased cattle showing no anti-bodies

This change to reduced virulence of Brucella abortus conforms with the basic principles of immunology, in this respect closely resembling the organism of syphilis Stokes says "While it has been shown that agglutinins and lysins for the spirochaeta pallida are found, the amounts are insignificant so far as inhibitive effect on the disease is concerned" The diagnosis of chronic brucellosis is as difficult as would be the diagnosis of syphilis without the aid of the Wassermann reaction Brucellosis syphilis are similar in protein manifestations, loss of clinical identity, their chronic course, loss of affinity for certain tissues, and in pathology, involving practically all tissues

The attenuation of the Brucella abortus has made the agglutination test of little value, the intradermal test does not distinguish past from active infection, the opsonophagocytic index is of questionable value, and culture work in diagnosis is limited by the difficulties of growing Brucella abortus. The procedure best adapted for diagnosis of chronic brucellosis would appear to be the complement fixation test, but more work will be required to establish definitely its reliability.

# Scientific Articles

# SURVEY OF RAGWEED POLLINATION IN THE NEW YORK METROPOLITAN DISTRICT IN 1946\*

EUGENE H WALZER, M.D. JEROME SHERMAN M.D. ROBERT A. CHAIT, M.D. and MATTHEW WALZER, M.D. Brooklyn. New York

(From the Division of Allergy Jewish Hospital of Brooklyn)

POLLEN counts taken in Central Park, Man hattan, and spot checks in other parts of New York City have previously been reported by Durham.<sup>1-7</sup> Pollen counts also have been made at the Jewish Hospital of Brooklyn for a number of years. An extensive pollen survey of the entire New York Metropolitan District has not been attempted previously. The recent adoption of standard technics for exposing and counting pollen slides by the Pollen Survey Committee of the American Academy of Allergy<sup>3</sup> has made such a survey possible for the first time.

The present study was undertaken for the following reasons (1) to determine the relative rangweed pollen concentrations in the various boroughs (2) to determine whether the pollen counts of Brooklyn and Manhattan, the only boroughs studied in the past, have been representative of the entire city, (3) to determine to what extent ragweed pollination in surrounding communities influences New York's pollen problem, (4) to collect data which might help to determine the effectiveness of the ragweed extermination campaign which is being carried on by the Department of Health in this city (5) to obtain further data on the relationship of meteorologic conditions to pollen counts

#### Technic

The technics employed in preparing, exposing, staining, and counting pollen slides in this survey were those recommended by the Pollen Survey Committee of the American Academy of Allergy The device designed by Durham was employed for exposing all slides. "Essentially it consists of two 9-inch heavy polished stainless steel disks set horizontally 3 inches apart and held with three struts. One inch above the center of the lower plane is a slide holder into which the slide fits snugly. The supporting rod of the

apparatus, 30 inches long rises from a tripod base equipped with holes so that it may be screwed to a solid platform. <sup>18</sup> Comparative studies were made with this slide shelter and an old shelter which has been in use at the Jewish Hospital in Brooklyn for the past eleven years. The latter consists of a flat wooden base measuring 8 by 8 inches and covered by a semicurcular metal roof 4 inches high in the center completely open at both ends, and partially open on the sides. The exposed slide was set in the center of the

base and held in place by two flat clips

Glass slides, frosted at one end were exposed daily at 9 00 A.M for twenty four hours. had been rubbed with a drop of a mixture con taining 75 per cent U.S.P petrolatum and 25 per cent U.S.P mineral oil The film was made as thin and as smooth as possible prevent contamination, all slides were stored in tightly covered slide-boxes at all times, except when exposed in the shelters or being counted To facilitate identification of the pollen granules, two or three drops of Calberia's staint were dropped on the exposed slide. This stained the pollen grains a deep reddish-purple. A cover alip 2.2 centimeters square was then placed on the slide. All the grains under the cover shp (4.84 sq cm.) were counted under the low-power objective of a microscope equipped with a mechanical stage. When there was difficulty in identifying pollen grains under low power, the high, dry objective was employed. By dividing the number of pollon grains under the cover slip by 4.84, the number of granules per square con timeter of slide could be computed. All figures in this report represent the number of ragueed granules per square centimeter of slide during a twenty four hour exposure To convert these figures to pollen grains per cubic yard of air, the count per square centimeter should be multiplied by 36. This factor applies only to counts for

Presented at the Semiannual Meeting of the Association of Allergy Clinics of Greater New York, November 12 1916.

<sup>\*</sup> This survey was made in collaboration with the Pollen Survey Committee of the American Academy of Allersy

<sup>†</sup> Calberia e solution: S co. of giveerin 10 ce. of 95 per cent alcohot 13 cc of distilled water; 2 drops of saturated aqueous olution of fuchsin.

pollen collected on slides exposed in the Durham shelter under standard conditions

A total of 850 slides were counted by two observers. The margin of personal error was reduced to a minimum by repeated checks on the same slides by both observers.

### Location of Exposure Stations

The areas, where exposure stations were set up, were arbitrarily divided into three zones (1) The inner zone consisted of the five boroughs of New York City, (2) The middle zone consisted of four localities within a 50-mile radius of New York City Included were Hewlitt and Mineola on Long Island, Verona in New Jersey, and Croton-on-Hudson in New York State (3) The outer zone consisted of two cities outside of the 50-mile zone, New Haven and Waterbury, Connecticut In addition, for purposes of comparison, counts by workers employing the standard technic were obtained from Philadelphia, Pennsylvania, Washington, D C, and Cleveland, Ohio

Exposures were made on the roof tops of buildings located as closely as possible to the geographic center of the community to be studied. The selected buildings were usually the tallest in the vicinity and were not flanked by nearby structures. The Durham shelter was always placed at least three feet above any nearby parapet or other obstruction.

The sites selected for exposure of the slides were as follows

Inner Zone — Brooklyn Jewish Hospital, Manhattan Belvedere Tower in Central Park, the Bronx Montefiore Hospital, Staten Island Sea View Hospital, Queens Rockaway Park, Rockaway Beach Hospital, Flushing the Chamber of Commerce Building, Ozone Park the Police Department Building

Middle /one—Long Island Hewlett, Fire Station Building, Vineola, Nassau Hospital, Verona, New Jersey, a five-story apartment building, Croton-on-Hudson, New York, a three-story high-school building

Outer Zone —Connecticut New Haven, Grace Hospital, Waterbury, Waterbury, Hospital

Several factors influenced the choice of localities for exposing slides. Some communities, such as Hewlett, on Long Island, and Rockaway Park, in Queens, were selected because hay-fever symptoms of patients, who lived in those areas, had, in previous years, been more severe than those of patients from other parts of the Mictropolitan district. Information on ragweed pollination in these places was, therefore, of clinical importance. Ozone Park in Queens was selected because it represented roughly the center of the land-mass occupied by Brooklyn and Queens, Mineola was chosen as a representative area for Nassau County. A station was set up at Croton-on-Hudson, New York, at the request of

the township, which was interested in a local pollen count. The following communities were selected because rehable workers, who were familiar with the technic recommended by the American Academy of Allergy, were available in these localities. Flushing, Queens, Verona, New Jersey Waterbury and New Haven, Connecticut, Philadelphia, Pennsylvania, Washington, D.C., and Cleveland, Ohio

Hospital roof tops were selected in Brooklyn, Manhattan, Staten Island, and the Bronx because of their height, and because reliable personnel were available at these institutions to change the slides daily

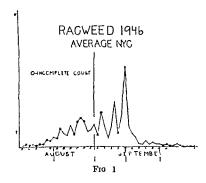
In most instances, stations were set up for the entire ragweed season, but, in a few places, such as Rockaway Park, Ozone Park, Hewlett, and Mineola counts were made for shorter periods of time.

The slides from all of the stations in the inner and middle zones, and from the two Connecticut stations in the outer zone were counted by the authors For counts in Washington and Cleveland, the writers are indebted to Drs E Kailin and H J Friedman, respectively These workers had carried on pollen studies in this laboratory, in previous years, and were familiar with the standard technic For the Philadelphia counts the writers wish to thank Dr G Blumstein, who also employed the standard technic

The old shelter was nailed to a parapet on the roof of the Jewish Hospital of Brooklyn, in the same position it had occupied in previous years. Counts were continued with this shelter as well as with the new standard instrument, so that comparative equivalents of the two technics could be obtained. The Durham shelter was placed alongside of the old shelter so that the exposure conditions for both instruments would be the same.

### Results

The results of the survey for each locality are presented in the graphs 'The daily figures noted in the charts represent the number of ragweed pollen granules per square centimeter of slide exposed for a twenty-four-hour period Circles represent days on which the pollen counts were incomplete because rain had partially washed The number of pollen granules out the slides lost from the slide on such days varied with the amount, force, and direction of the rain those few days when the exposed slide either was broken accidentally or completely washed out by heavy rainfall, the count was estimated and represented on the chart by a small square estimates were obtained by averaging the counts in the surrounding area. This procedure was adopted in order to minimize the statistical error which would result if such counts were omitted entirely or counted as zero In Figs 2 to 10, inclusive, the average counts for New York City are presented for comparison with those of the other localities studied

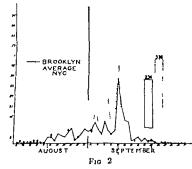


The blocks on the charts represent seasonal totals for each community obtained by adding the daily counts at that station. These are compared with the average totals for New York City, computed from counts taken on the same days.

#### Inner Lone

Average Pollen Counts in New York City The counts for all of the boroughs were aver aged every day, and the figure thus obtained was considered the average daily pollen count for New York City In Fig 1 the average daily counts for New York City are recorded for the entire season in terms of the number of pollen grains per square centimeter of slide. The first traces of ragweed pollen appeared in New York City on August 11 The pollen counts for Greater New York were minimal until August 23, when a count of 10 was obtained There was a gradual rise in pollen concentration until Au gust 28, when a count of 17 the highest for that month was reported In September counts of 20 and 26 obtained on September 3 and 7, respectively, were the high points during the first mne days of the month On September 10 a count of 46 represented the peak of the season On September 12 the count dropped to 8 and for the remainder of the season there were only traces of ragweed pollen in the air

Brooklyn The pollen counts in Brooklyn were the lowest obtained in any of the boroughs (Fig 2) The first traces of ragweed pollen appeared in Brooklyn on August 11 and throughout all of August the daily counts of 12 and 13 were obtained A count of 39, on September 10 was the highest obtained in Brooklyn for the season the average count for the city on this date was 46 Thereafter the count dropped



precipitously and was minimal for the remainder of the season. The total seasonal pollen count for Brooklyn (230) was approximately two thirds that of the average for New York City (338)

Queens Two stations were set up in Queens one for the entire sonson in Flushing the other, a roving station in Rockaway Park from August 13 to 27 inclusive and in Ozone Park, from September 4 to 23 inclusive

(a) Flushing Pollen counts in Flushing throughout most of the season were below the average for New York City (Fig. 3) From August 11 to August 22 there were only traces of pollen on the slides Thereafter, there was a slight increase in pollen concentration until August 30 when a count of 10 the highest for the month was reported A count of 27 on September 3 was the highest peak of the season for this station. It was unfortunate that on September 10 when the average count for New York City was 40 the slide in Flushing was completely washed out by a local rainstorm.

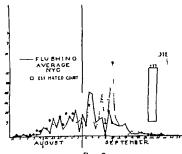
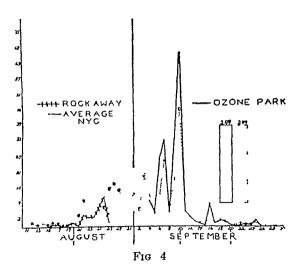


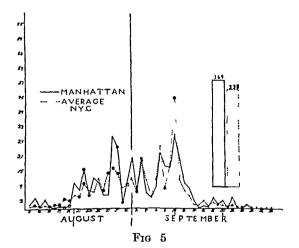
Fig. 3



The total seasonal pollen count in Flushing (227) was slightly below that of the average pollen count in New York City (338)

(b) Rockaway and Ozone Park For the twelve days during which the roving station remained in Rockaway Park, the counts were slightly lower than the average for New York City (Fig 4) During the time the station was located in Ozone Park, there were two peaks 29 on September 7, and 68, the peak for the season, on September 10 Totals for the season for comparative days of exposure were equal for Rockaway-Ozone Park and New York City

Manhattan This station was set up at Belvedere Tower in Central Park, on August 11, 1946 There was a count of 16 on August 22, the highest until August 28, when the ragweed count was 29 (Fig 5). During the first week of September, the pollen concentration remained high, with counts of 21 on September 1 and 3, and a count of 23 on September 7 The peak for September occurred on the tenth, when a count of



BRONX
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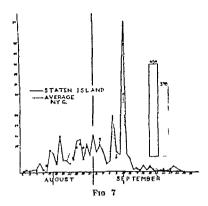
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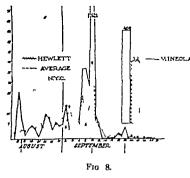
FIG 6

30 was recorded Thereafter, the pollen concentration diminished rapidly, and, by September 18, the count was very low The seasonal total for Manhattan (369) was approximately the same as that for the entire city (338) Moreover, during most of the season, Manhattan was the borough which most closely followed the average daily count for Greater New York

Bronx The pollen shelter was placed at the Montefiore Hospital on August 11 len counts for the Bronx during most of the season were found to be above the average for New York City (Fig 6) During the period from August 11 to 21, there were only traces of ragweed pollen in the air, but on August 22 the count rose to 15 Thereafter, throughout August, there was a steady increase with peaks of 35 and 46 on August 25 and 27, respectively The count fell somewhat during the last four days of August, but there was a rise in September with peaks of 22, 48, and 41 on September 3, 7, and 10, respectively The peak for the season occurred on September 7 On September 10, the estimated count for the Bronx was slightly lower than that of the average for New York City The seasonal total for the Bronx (394) was slightly above those for the average of the five boroughs (338)

Staten Island Pollen counts for Staten Island were higher than those for the average of New York City for the season (Fig 7) The first significant pollen spill in Staten Island occurred on August 19, when the count was 13 August, the highest counts obtained were 21 and 19 for the 22 and 28, respectively During the first week of September there were two significant counts 21 on the first, and 33 on the The peak for the season, a count of 88, seventh was recorded on September 10, when New York had its peak of 46 After September 10, the





counts in Staten Island were low The total for the season in Staten Island (454) was greater than the average for New York City (338)

#### Muddle Zone

Hewlett and Mineola Exposures were begun in Hewlett on August 18, 1946 On August 19 this station had a count of 27 a pollen spill not found in New York City (Fig 8) Thereafter, and until September 3, the counts paralleled those of New York City and were below 20 The shelter was then moved to Mincola exposures were made there from September 6 to September 29 In Mineola the counts were higher than those for the average of New York On September 7, a count of 42 was obtained. This concentration was maintained until September 10 when there was a great spill and the count at Mineola rose sharply to 162 was the highest count obtained in our survey of the Inner and Middle Zones The drop thereafter was precipitous and the pollen count here, as in New York City, was negligible for the remainder of the season Comparative totals over the same period of time showed Hewlett and Mineola (469) to have an appreciably higher pollen concentration than the average for the five boroughs (312)

Croton-on Hudson Pollen studies were begun in Croton on August 14 The first appreciable pollen spill occurred on August 20, when a count of 40 was obtained (Fig 9) A lower peak of 33 was recorded on September 1 Neither of these peaks was noted in the New York City counts. The peak of 50 on September 10 approximates that which occurred in New York City on the same day The count thereafter was minimal. The total seasonal count in Croton (326) was

approximately the same as that of the average for New York City (335) during the corresponding peniod of time.

Vorona, New Jersey Pollen studies were begun in Verona on August 29 The counts roughly paralleled those of the average for New York City until September 8 (Fig. 10) On September 9, Verona had a peak of 30, while the peak of 46 in New York City occurred on the following day Although the counts in New York City thereafter were negligible, a count of 15 was obtained in Verona, on September 19, and another of 29 on September 23

The latter rise was due to a local storm with a wind of high velocity. The total seasonal count in Verona (262) was slightly higher than that of the average for New York City (242) over a comparative period of time.

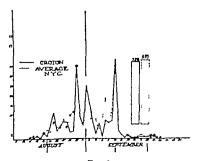
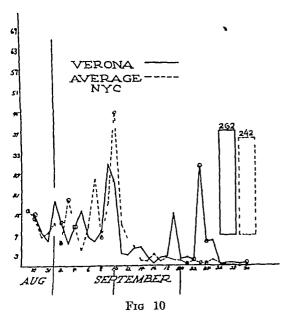


Fig 9



### Outer Zone

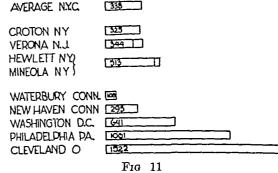
In Waterbury, Connecticut, the total pollen count of 108 for the season was extremely low (Fig 11) In New Haven, Connecticut, the total count of 295 was lower than that of the average for New York City In Washington, DC, the count of 641 was roughly twice that for New York In Philadelphia, Pennsylvania, the seasonal total of 1,061 was approximately three times that of the average for New York In Clevel ind, Ohio, the total count of 1,522 was four and one-half times the average for New York City

# Comparison of Ragweed Counts for the Seasons of 1946 and 1945

The Durham shelter has been in use during the past two years Ragweed pollen counts were made with this shelter in Brooklyn, Manhattan, and Philadelphia for part of the 1945 season and for 1946

Brooklyn counts suitable for comparison were available for the same twenty-one days in both seasons. In Brooklyn, it was found that the total twenty-one-day pollen count in 1946 was 70 per cent of that obtained in 1945 (Fig. 12). In Philadelphia comparative studies for the entire two seasons showed the 1946 ragweed pollen count to be 68 per cent of that obtained in 1945.

In Manhattan the site of exposure used in 1945 was found to be unsatisfactory In 1946 it was moved to a more suitable location A comparison of pollen counts for the same twenty-three days in the two years revealed the 1946 ragweed pollen count to be 88 per cent of that



recorded in 1945 This percentage is at variance with the percentages for Brooklyn and Philadelphia The discrepancy is probably due to the inadequacies of the 1945 exposure site

### Counts Obtained with Old Shelter in Brooklyn in 1946

In 1945 and 1946 the Durham shelter was placed adjacent to the old shelter on the roof of the Jewish Hospital of Brooklyn, in order that the slide exposure would be the same for both instruments. The total pollen count (886) obtained with the old shelter in 1946 was 48 per cent of the average seasonal count (1,827) recorded for that instrument from 1936 to 1946, inclusive (Fig. 13)

#### Discussion

In the Inner Zone the pollen counts in Brooklyn and Flushing were lower than the computed average for all five boroughs Counts in Manhattan and Rockaway-Ozone Park approximated the five-borough average, and counts in Staten Island and the Bronx were above the average for the five boroughs

In the Middle Zone counts for Croton and Verona were approximately equal to those of the average for the five boroughs, whereas pollen counts in Hewlett and Mineola were above those of the city. In the Outer Zone Connecticut pollen counts were lower than those in New York, but counts obtained in Philadelphia, Washington, and Cleveland were all higher than those of the Metropolitan area.

Of the five boroughs, the pollen curve for Manhattan most closely approximates that of the average for the city Brooklyn counts were lower than those of the city as a whole Whether these relationships will continue to apply in future years, when the pollen seasons are more normal, remains to be determined

It is apparent that the ragweed pollen crop in New York City was light in 1946 This scarcity of pollen was noted also in other parts of the eastern United States Counts in Veiona, New

#### RATTO 1946-45 WITH DURHAM SHELTER

BROOKIN REJORANT CAN FOR TO TOX HANNER PROMITE 1 - 1 1.7 88% 68% PHEADELPHA READON' TO Some

Jersey, Croton, New York, Waterbury and New Haven, Connecticut, were either of the same order or lower than those in New York City In Brooklyn and Philadelphia, where the same technics were employed during 1945 and 1946, the pollen counts for the 1946 season were lower than those obtained in 1945. The percentage relationship of the counts for 1946 and 1945 in Brooklyn (70 per cent) and Philadelphia (68 per cent) closely approximate each other should be pointed out that of all the localities studied New York City was the only community in which a ragweed extermination campaign was in progress in 1946

Although the seasonal total for 1946 in Brooklyn with the old shelter was only 45 per cent of the average obtained during the past eleven vears, this is not the lowest seasonal total rag weed pollen count recorded at the Jewish Hospital In 1937 a scasonal total of only 702 was obtained

The 1946 ragweed pollen season was not only light but its onset was delayed about ten days. In Brooklyn two peaks usually occur each year one during the last week in August, and another during the first week in September In Brooklyn, during August, 1946 ragweed pollination was n gligible It was not until September 10 that an appreciable pollen count was recorded Manhattan the Bronx, and Staten Island counts did rise during the last week of August, but at almost every station including those from the middle and outer zones, the highest counts for the reason did not occur until September 10

It is quite possible that the commendable efforts of the New York City Department of Health in the ragweed extermination campaign may have had some influence in lowering the pollen counts in 1946 Because this campaign was carried on in a year when ragweed pollenation was light, its value cannot be estimated. It is quite possible that a continued intensive campaign in New York City as well as in the surrounding communities may affect the local pollen counts. Until surveys are made for several years, it will not be possible to estimate the effectiveness of the regweed elimination campaign.

The poor ragweed pollen crop in the middle Atlantic States in 1946 may in part be explained by meteorologic conditions Mr. Fred Hodgson

# OLD SHELTER **BROOKLYN**

TOTAL 1946	886	48%
AVERAGE TOTAL 1936 1946	1827	1076
	73 10	

botanist, in Verona New Jersey stated that 1946 was a poor season for pollen collection not only for ragweed, but also for trees and grasses He attributed this paucity of pollen to lack of sunshine An examination of weather data shows a diminution in sunslane during May and June when the total sunshine recorded was 15 per cent below the average possible sunshine for those two months There was an excess of rain in May and June, \$1 per cent above average for May and 44 per cent above average for June The meteorologic conditions in July 1946 were average in all respects but August was an ususual month The sunshine in August was 13 per cent below average The mean temperature in August was 2.5 F below the normal On twenty one of the thirty-one days, or 65 per cent of the month, the temperature was below normal During August, the wind velocity was below average on eighteen of thirty-one days or 60 per cent of the time The rainfall in August was 0.81 inch below normal or 18 per cent below the usual precipitation. Although the amount of sunshine in September was greater than usual it was below the average for ten of the first fifteen days, or 66 per cent of that time The temperature was average for 60 per cent of the time for the first fifteen days During the period from September 1 to 15, the wind velocity was below average for 80 per cent of the time

Thus in May and June when the ragweed was developing there was excessive run and a diminished amount of sunshine In August and during the first two weeks in September, when the plants should have been reaching maturity and releasing their pollen there were less than normal amounts of sunshine rain, temperature and wind This may very well account for the light, late crop in 1916

#### Summary

A pollen survey of New York City and its Metropolitan area was undertaken employing the standard technic outlined by the Pollen Survey Committee of the American Academy of Allergy

2 The pollen counts in New York City were low in 1946 Seasonal totals for the boroughs in

the order of increasing pollen density were Brooklyn, Flushing (Queens), Manhattan, Rockaway-Ozone Park (Queens), Bronx, and Staten Island

3 Pollen counts in Manhattan were most representative of the city as a whole

- 4 Seasonal ragweed pollen totals in Croton, New York, and Verona, New Jersey, were approximately equal to those of New York City Counts at two stations in Connecticut were lower than those of the New York Metropolitan area Counts in Hewlett-Mineola, Washington, D C, Philadelphia, Pennsylvania, and Cleveland, Ohio, were higher than those for New York City
- 5 The peak for the season, at most stations, occurred on or about September 10 The ragweed pollen crop in 1946 was late in maturing and was relatively light
- 6 The explanation for the scant pollen crop is probably to be found in meteorologic conditions which, from May through September, 1946, were unfavorable to the growth and development of ragweed plants

7 The data available at present is insufficient to evaluate the effect of the city ragweed extermination campaign

Note The authors are indebted to the following whose conscientious assistance and cooperation made this study possible Mr David Morris New York City Dr Harold Rifkin, Montefiore Hospital, Bronx New York, Dr S Semior Sack Flushing, New York, Dr L Rubenstein Sea View Hospital Richmond, New York Miss Marie Arnold, Rockaway Beach Hospital Queens, New York Capt. Frank Kelly, Chief of Police Hewlett, New York Mr William Grant Hewlett Fire Department, Howlett, New York Dr A Victor Landes, Harmon, New York, Mr Fred Hodgson Verona New Jersey Dr Barnett Freedman, New Haven Connecticut, and Dr Sidney Jennes, Waterbury Connecticut

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### PRIZE ESSAYS

The Merrit H Cash Prize and the Lucien Howe Prize will be open for competition at the next Annual Meeting of the Medical Society of the State of New York, May 17, 1948, in New York City

The Lucien Howe Prize of \$100 will be presented for the best original contribution on some branch of surgery, preferably opthalmology. The author need not be a member of the Medical Society of the State of New York.

The Merrit H Cash Prize of \$100 will be given to the author of the best original essay on some medical or surgical subject. Competition is limited to the members of the Medical Society of the State of New York, who at the time of the competition are residents of New York State.

The following conditions must be observed Essays shall be typewritten or printed with the name of the Prize for which the essay is submitted, and the only means of identification of the author shall be a motto or other device. The essay shall be accompanied by a sealed envelope having on the outside the same motto or device and containing the name and address of the writer.

If the Committee considers that no essay or contribution is worthy of a prize, it will not be awarded

Any essay that may win the prize automatically becomes the property of the Medical Society of the State of New York "to be published as it may direct"

All essays must be presented not later than February 1, 1948, and sent to the Chairman of the Committee on Prize Essays of the Medical Society of the State of New York, 292 Madison Avenue, New York.

Chas Gordon Heyd, M.D., Chairman Committee on Prize Essays

### COMMON SENSE IN INFANT FEEDING AND THE USE OF VITAMINS

A CLEMENT SILVERMAN, M D Syracuse New York

(From the Department of Pediatrics Syracuse University College of Medicine)

IT HAS been well said recently that "the foundation of the physical fitness of a people is embedded in the feeding and care of the nation's infants" In adhering to the title assigned me it is obviously necessary to emphasize the common-sense aspect of infant feeding Since it is generally agreed that the milk of a healthy mother is the most nearly perfect food for the infant, common sense would indicate that ma ternal nursing is the most natural method of infant feeding

Though in the last two decades artificial feeding has become simplified and has been remarkably successful, there is great need to encourage breast feeding among prospective mothers After thirty years of pediatric practice I have the distinct feeling that many of the difficult feeding problems of the first month or two of life would be avoided if the start were made with breast feeding

Since the fall of 1943 the Nutrition Foundation has launched a re-investigation of human milk and a comparison with cow's milk. The analyses were made by the Research Laboratory of the Children's Fund of Michigan and the study generally was made with the cooperation of the obstetne and pediatric departments of the Ford Hospital in Detroit, while the comparative values for cow's milk were carried out at Cornell The September, 1945 issue of the American Journal of Diseases of Children's devoted to some of these newer human milk studies

In consecutive observations of 900 women, it was found that six out of seven who attempt nursing will have an adequate supply by the fifth postpartum day, and only one out of seven will show a deficiency of lactation. The chances for full breast nursing were found to be from 65 to 74 per cent. In no instance was it necessary to take a baby off the breast because the milk did not agree with it. Nevertheless, breast feeding in Detroit hospitals was found to range from 5 6 to 69 per cent. Such a variation cannot represent physiologic differences but must be purely artificial

With respect to babies who were never put to the breast the most important single factor was refusal on the part of the mother to attempt nurang, this accounting for 40 per cent. Many mothers held the view that bottle feeding was as good, or even superior, to breast feeding Some had fear of gaining weight, or that the breasts would change their shape, or become pendulous. Others were afraid that it would interfere with home, business, or social duties

It is generally recognized that there are certain contraindications to maternal nursing. These may be listed as (1) acute illness, (2) mastitis, (3) cracked or fissured nipples or painful breasts, (4) pregnancy, (5) Rh plus infant of an Rh negative mother (6) allergy to mother's milk, (7) milk supply less than one third of the calone requirements.

It is obvious that if breast feeding is to be en couraged a good deal of the encouragement will have to be done by the obstetrician. His relationship to his patient is such that he can exert a tremendous influence in this direction. The quality of the milk depends upon the diet, and the obstetrician's prenatal advice surely includes a suitable dietary regimen. He can point out that her physical obligation to the child, begun at the onset of pregnancy, should carry through the lactation period, and he can prepare her for it.

But even before the obstetrician comes upon the scene, perhaps in the latter part of high school it could be emphasized that nursing is a basic mammalian pattern and that through the ages it has been natural for a mother to nurse her child Maternal nursing supplies physiologic and emotional stimulation and fulfillment. It makes for a stronger bond between mother and child and there is likely to be a sense of loss if the mother does not nurse her child. The newborn on his part has the same organic needs as other young mammals he needs close tactual contact, cud dling nuzzling mothering and the opportunity to suckle and use his lips Breast feeding thus, should be a satisfying experience for both Under normal conditions mother and child there is no known disadvantage.

Even after the baby is born the pediatrician often finds it possible to persuade the mother to maternal nursing, though she had not intended and had not been prepared to nurse. Emphasis must be put upon the dynamic process of maternal nursing rather than on the milk per se. Mothers may be reassured that they need not gain weight, that they may eat any food which agrees with them, and that they will not hurt the baby by moderate smoking. By introducing one bottle feeding a day for which breast milk

Presented at the 141st Annual Meeting of the Medical Bodiety of the State of New York, Buffalo Teaching Day May 6, 1947

may be used when it is abundant, the mother need not be tied down and may get an opportunity to go out socially or for business purposes. In general it should be made clear that maternal nursing will not continue for the whole first year, but that the important time is the period of the first three or four months, and the first month the mother is pretty much out of circulation anyhow. Food is introduced nowadays by the end of the second month, and unless the milk is particularly abundant nursing can be abandoned during the third or fourth month. For those who need it, reassurance may be given that the shape of the breast is changed rather by pregnancy than by nursing.

Success in breast feeding is dependent upon adjustments during the first few days, so that the first feedings will not become contests between mother or nurse and the baby, and what should be a pleasurable experience converted into unpleasant conditioning Recent observations by Norval<sup>3</sup> on the sucking response of fifty newborns at the breast showed that only ten were vigorous and sucked actively or even greedily, two were poor, and thirty-eight average last group grasped the nipple but tended to fall asleep, they could be started again, however, by a gentle pat The poor ones made only short feeble attempts at sucking She concludes that the average early response is not a greedy one but characterized by dallying and repetitious trials This should be met with patience at nursing and calm attempts to allow the baby to learn the gratification he can get from nursing, rather than with vigorous, unpleasant stimulation to this sensible viewpoint is the mechanistic manner in which infants are often handled in hospital nurseries with their rigid adherence to clock schedules Most of the difficulties could be avoided by attempting to conform to the infant's natural pattern and reflex responses plying the baby's cheek to his mother's breast will start him rooting with his mouth for the nip-Actual suckling follows the application of the nipple to the lips

# Artificial Feeding

It may seem paradoxical that after urging maternal nursing, I should now point to the highly successful feeding with cow's milk formulas. At present there is little enthusiasm for the establishment of wet-nurse registries. Even prematures have been found to do as well and even better on cow's milk formulas than on human milk <sup>4.5</sup> It has been pointed out that for infants too weak to be put directly on the breast, the feeding of human milk becomes an artificial procedure <sup>4</sup> This implies confirmation

of our emphasis on maternal nursing as a dynamic process rather than on human milk per se

Artificial feeding must be considered as a substitute for breast feeding. It became established through studies based on breast feeding. Twelve years ago, Dr. Grover Powers<sup>6</sup> of Yale gave a classical paper before the pediatric section of this Society, in which he traced the historical background of artificial feeding. Perhaps the two main contributions to the success of artificial feeding came from (1) better care of milk bacteriologically (pasteurization, refrigeration), (2) boiling milk to change the protein for better digestion.

Whether breast-fed or bottle-fed, the nutrition of the infant implies certain principles, which are not a matter of common sense but of scientific development. These will now be considered briefly <sup>7</sup>

Fluid Requirements—While the exact requirement for water has not been determined, it is relatively high during infancy. In the first half year, 2 to 3 ounces per pound per day is necessary Naturally, it varies with age, food intake, activity, surrounding temperature, and other factors. Ordinarily, the water requirement is met by the satisfaction of thirst. It is in sick infants that the chief danger of insufficient water is encountered, especially when there is vomiting, diarrhea, high fever, or excessive sweating. Both human and cow's milk have a water content of 87.5 per cent.

Caloric Requirement — The clinical measure of success in meeting calonic heeds is based on growth, general well-being, and satiety number of calones ingested can be safely left to the baby when the milk supply is adequate, except in the case of sick, feeble, or premature infants The full-term baby requires on an average 50 to 55 calones per pound, at one year, it is about 45 calories per pound For practical purposes, human and cow's milk can both be considered to yield 20 calories per ounce perience has shown that the proper distribution of calories is protein 15 per cent, fat 35 per cent, and carbohydrate 50 per cent In human milk, protein represents approximately 8 per cent and fat may be up to 50 per cent

Protein—As the word indicates, protein holds first place as an essential nutrient. Its nutritive value depends, so far as is known, only on the kind and number of amino acids of which it is composed. Of the twenty-two amino acids, ten have been found, by feeding experiments in rats, to be necessary for growth and development. One cannot say, however, that the other fourteen or more constituent amino acids are of no importance. Reliance for growth and

maintenance of health remains with the natural protein foodstuffs. Proteins of animal origin are about twice as efficient as those of vegetable On the basis of weight, an infant reouires approximately three times as much protein as an adult, as is also true for calories and The protein needs of a breast-fed infant are apparently met with 8 per cent of the total calories, with cow's milk it has been found ad vesible to give about 10 to 20 per cent premature infants, the higher level of protein in take is advocated, the explanation being that many of these infants have difficulty in digesting and absorbing fat a Human milk when fed in the amounts needed to meet the lugh requirements for maintenance and growth necessitates an excessive fluid intake and too high a level of fat. sometimes exceeding the tolerance. For these reasons heated cow's milk mixtures are often preferred for premature infants. 4.8.8

Protein besides being adequate in quality and amount, also must be denatured in order to produce fine curls. This is done in various ways, boiling being perhaps the most common. This also explains the present popularity of evaporated

milk

The protein needs in the breast-fed are not by 2½ ounces per pound. Cow's milk provides it with 1½ to 2 ounces per pound with a total of not over a quart for twenty four hours. With evaporated milk, from four-fifths to one ounce per pound is needed and the total for twenty four hours need not exceed one tall cau, or 13 ounces.

Fat—The human caloric requirements for fat are not well established. Of the various hilds, those known to be important nutritionally are fats (triglycerides) even though they may be synthesized in the body, unsaturated fatty acids, linoleic and arichidonic, which are not synthesized and certain plant sterols principally ergosterol which yields vitamin D on irradiation.

Cow's milk contains approximately 3 5 per cent fat It is more variable in breast milk which contains relatively larger quantities of the more readily absorbed clein Volatile fatty acids account for about 2.5 per cent in breast milk and 27 per cent in cow's milk

Carbohydrate —Lactoso makes 4.5 per cent in con's milk but 6.5 per cent in human milk Some form of carbohydrate to the extent of one-half to one onnee is usually put into formulas Recently there has been a tendency to keep the added sugar low or to leave it out entirely \*.\*\*

Minerals or Salts—The child's requirements for salts are relatively higher than the more maintenance requirements of the adult. It has been estimated that for each gram phosphorus retained in the body 0.3-Gm minerals also is deposited, so that if the protein is adequate the necessary inorganic material will be provided

Cow's milk contains three or four times as much mineral as human milk, but neither contains an adequate amount of from They have to be supplemented especially in promutures. In addition to iron, jodine calcium, and fluorine are likely to be deficient in amount and may need to be supplemented.

Construction of Formula -- The formula consists of milk water, and sugar Pyaporated milk has many advantages since the process alters the casein so that the curd is softer and smaller than that of boiled milk and approaches that of breast milk. It is also less allerconic. McCollum' recently has developed a supplemented evaporated milk, Formulae containing adequate amounts of vitainins and minerals The preceding principles can serve as a guide to the simple construction of formulas Since no two babies are exactly alike, the initial formula will have to be modified on the bans of the infant's response as shown by his growth and satisty. As solid food is added to the infant s diet there is practically never any need to give more than seven or eight ounces of milk at an individual feeding, or more than a tall can of evaporated milk, or more than a quart of whole milk during a twenty four hour period hardly should need emphasizing at this time that it is a human being who is to drink the formula that he seems to know how much he wants at his feeding and that he may wake up carly or late, or may ery for reasons other than hunger There is no basis in physiology for giving every ten-pound infant five feedings of exactly six ounces each, having a value of 500 calones.

Vitamins -Vitamins C and D have to be supplemented whether the buby is breast fed or bottle fed Of vitamin D 400 to 800 units daily are necessary and a greater relative amount is required by prematures. The vitamin D supplement provides also vitamin A. The need for A is greater in children with faulty fat absorption or liver disease. The average requirement for C is 30 mg but prematures need rela tively larger amounts, two or three times the average amount to aid in the metabolism of tyrosine and phonylalanine. Bottle-fed infants should receive ascorbe and or orange juice within the first weeks of life. The requirement in infants for macin is given as 4 mg, and for riboflavin and thiamin 0.4 mg each. Cow's milk contains 38 micrograms of thiamin per 100 ce while mature human milk contains, on the average 14 micrograms Similarly, broast milk

10

contains much less riboflavin than cow's milk, 37 micrograms compared with 200 micrograms On the other hand, breast milk is per 100 cc richer in macin, containing 183 micrograms in contrast to 85 in cow's milk per 100 cc When solid food also is given, it is obvious that the chief constituents of the vitamin B-complex are supplied ordinarily in sufficient amounts, though during fever or diarrhea the need for thiamin may be increased

# Summary

Common sense in infant feeding implies mu-The reasons for the decline in ternal nursing breast feeding are considered and the need for re-education is emphasized Maternal nursing as a dynamic process is stressed The principles governing infant feeding and vitamin require-

In both maternal nursing ments are reviewed and artificial feeding, cognizance is taken of the psychologic approach

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# INDUSTRIAL MEDICINE

As recently as twenty-five years ago, a physician who accepted a position in "Industrial Medicine" was considered to have stepped down from a high professional plane to one distinctly lower It was assumed the quality of medicine practiced would be lower and that the doctor would become more and more commercially minded

Today, we see a very different picture Every great commercial or industrial organization has its medical department, and in some communities these departments are the leaders in professional advancement This development has gone hand in hand with expanding Public Health Departments, both state and national, and has been in step with the developing plans for prepaid medical and hospital care which have sprung up all over the industrial parts of this country

The vision and generosity of leaders of industry have been the chief factors in this growth Men capable of building a great complex business organization are men who understand using the best materials and employing the best workers When they began the medical departments of their industries they used the best equipment and they employed the best available nurses and doctors, or if they did not start this way their business sense soon showed them their mistake and they High rectified it with vigorous business action officials began to study other medical departments, began to inform themselves as to new public health methods, and the medical staffs were encouraged to broaden their field of activity What business asked of its medical men and women was a clear story of how to justify some additional installation If it paid in added efficiency, time saving, and better health of the employee, the cost could be met Too often the general public fails to understand how deeply the leaders of business feel their responsibility toward their personnel Even in so-called hardboiled organizations the welfare of the staff is a matter of importance, and this feeling of group unity has been one of the reasons for the development of industrial medicine to its present high level.

Today, industrial medicine is a well-developed branch of public health and is recognized and valued by the other subdivisions of the profession Last fall when the community was urged to inoculate against virus influenza, A and B, the medical departments of industry were among the first to act on this recommendation And recently in New York, all medical departments were vaccinating their personnel against smallpox, thus relieving the strain on hospitals and other public vaccination centers which would have been overburdened by the rush of people to protect themselves from infection.

As an educating force in the community, industrial medical departments rate high The constant example of careful work, good equipment, and intelligent advice is teaching a large and important element of the population higher standards of medical practice. All in all, the medical world has benefited by these departments and we may look for their continuance and their improvement through the years to come — Editorial, Journal of the American Medical Women's Association, June, 1947

# THE IMPORTANT INGREDIENT

It is often overlooked that the ultimate control of tuberculosis will depend upon the effectiveness of the training given to the infected individual. Case finding in tuberculosis is of little value unless it is followed by treatment, to go to a sanatorium is not as important as to remain there until the disease is arrested, the permanence of the arrest in any case of tuberculosis is always a matter of personal discipline and vigilance At every step of the road the physician must keep the conscious active cooperation of the patient.

This comes about only when continuous education of the patient is carried on by the physician and those associated with him.

# THE STUDY OF CERTAIN PATHOLOGIC PROCESSES WITH THE AID OF ISOTOPIC HYDROGEN\*

DeWitt Stetten, Jr MD, PhD, Boston Massachusetts

(From the Department of Biological Chemistry, Harvard Medical School)

DURING the past several years my collaborators and I have concerned ourselves largely with a study of the origin and fate of the reservoirs of carbohydrate and fat in the intact animal in health and disease—a study in which we have had frequent occasion to use isotopic tracers as an experimental device. In order to permit the presentation of our experimental results in proper perspective, it may be profitable to review briefly some of the underlying blochemical ideas current today.

Fig 1 presents a scheme familiar to most of you in which the several sources and fates of glucose are depicted. Glucose arises from carbohydrate of the diet from the breakdown of glycogen, and from synthesis from lesser fragments, and it may be pointed out that the latter two processes entail the hydrolysis of glucose-6-phosphate, a reaction that occurs in liver but not in muscle. Glucose in turn has many fates, notably its conversion into glycogen, fat, 3-carbon fragments, ultimately CO<sub>2</sub> and H<sub>2</sub>O among others, but in so far as is currently known, an initial phosphorylation catalyzed by the ubiq uitous enzyme hexokinase is an obligatory first step

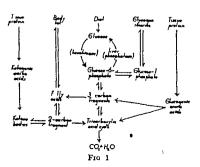
There is ample evidence for the occurrence in

the animal or in isolated systems of the several processes just outlined Of the relative rates of these reactions in the normal healthy animal. and of the alterations of these rates in disease relatively little is known with assurance biochemical analysis of the disease process often proves to be, not the institution of a new chemical reaction, nor the abolition of some normally occurring process, but, rather, an alteration in the rate of some normally occurring reaction In our studies we have considered the rates of glycogen synthesis under various conditions, the rate of glycogen breakdown, the rate of glucose synthesis from small fragments, and the rate of fatty acid formation. All the studies to be reported have been carried out on intact animals. in most instances in a uniform state of nutrition

First, a few words about technic. When deuterium oxide, heavy water, is added to the body fluids of an animal no perceptible change occurs in the functioning of that animal ever, from that moment on, in so far as stable hydrogen is introduced into the molecules of any synthesized compound, deuterium will appear in that compound, and as newly synthesized molecules replace pre-existing, nonisotopic molecules the deutenum concentration in that compound will nee toward some maximum value, tmax achieved experimentally only at infinite time. Clearly the rate at which new molecules are replacing old will be related to the rate at which the isotope concentration is approaching this maximal value The equation presented in Fig 2 represents the relationship between the isotope concentration, and time t when certain experimental conditions are met. k is the fraction of tissue constituent replaced per unit time. You will note that k is the slope of a straight line obtained when ln in in it is plotted

Presented at the 141st Annual Meeting of the Medical Society of the State of New York, Buffalo, General Sessions, May 7, 1947

<sup>\*</sup> The experimental work herein reported was carried out with the aid of grants from the Nutrition Foundation Inc and the Josiah Macy Jr., Foundation



$$k_{i} = \frac{1}{\ell} \ln \frac{\ell_{max}}{\ell_{max} - \ell}$$

against 1t.

TABLE 1

	PER C	ENT OF DEUTER	RIUM IN
	Fatty	Liver	Carcass
Days	Acids	Glycogen	Glycogen
0 125	54	0.6	1 7
i	15 5	19 6	3 0
2	21 9	16 4	6 1
4	27 8	23 6	96
8	35 8	28 8	19 9
16	37 8	28 9	24 3
<b>6</b> 0	37 9	28 9	25 5

TABLE 2

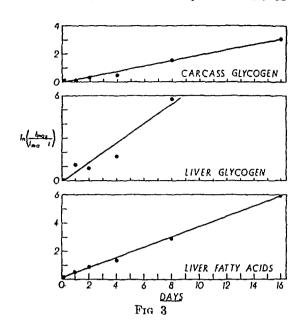
	L Days-1	t1/ Days
Liver fatty acids Liver glycogen Carcass glycogen	0 37 0 68 0 19	1 9 1 0 3 6

Given in Table 1 are analytic data for liver and muscle glycogens, as well as liver fatty acids, in normal adult rats on uniform high carbohydrate diets and at constant weight  $^1$ . The rise in deuterium concentration of each constituent with the passing of time will be noted, and the extrapolated values for infinite time are also included. For the graphic analysis of such data plots of  $\ln \frac{1_{\max}}{1_{\max}-1}$  against time are prepared (Fig.

3) and the slopes of the best straight lines determined. The numerical values of these slopes are given in Table 2. It will be seen that each day some 70 per cent of liver glycogen, and some 20 per cent of muscle glycogen are replaced by newly synthesized material in the normal adult rat.

Stated another way, the half life of liver glycogen is about one day, of muscle glycogen about three to four days. Combining these figures with the quantities of glycogen known to occur at these sites, one may calculate readily the weight of glycogen synthesized and destroyed daily by these rats. The value arrived at was 0.44 Gm per day. In other words, only about 0.5 Gm of glucose was consumed each day in the maintenance of the body glycogen stores, and this in spite of the fact that our rats were eating 1.5 Gm of glucose daily in their diets, or 30 times as much

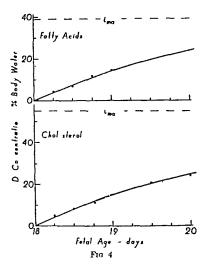
With the fate of only some 3 per cent of the ingested glucose accounted for as glycogen, the fate of the remainder was naturally a matter of interest. From similar data obtained from the body fats, it could be shown that about 2 Gm of fatty acids were synthesized each day by rats on a fat-free diet to replace body fat that was simultaneously being destroyed, and it could be estimated that some 5 0 Gm of glucose were consumed in this process. In other words, about



10 times as much glucose was utilized each day to replenish body fat stores as to replenish body glycogen

The conclusion that we have reached on the basis of this type of study is that the rat not only contains a great deal more fat in his body than glycogen, but, in units of grams per day, he turns over a great deal more fat each day than glycogen. A much larger fraction of the carbohydrate of his diet is consumed each day in the maintenance of body fat than in the maintenance of body glycogen stores.

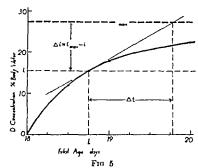
An interesting contrast to this situation in the adult rat is that provided by the rat fetus fetus in general is notably poor in depot fat and extraordinarily rich in glycogen Whereas the adult rat contains from 20 to 50 times as much fat as glycogen, the rat fetus contains about equal quantities of these constituents We have completed just recently a series of studies on this interesting experimental animal, employing much the same technic as that previously employed in the adult 2 We observed, in other words, the rate of the incorporation of deuterium into fatty acids, cholesterol, and glycogen of the eighteenday rut fetus after the administration of heavy water to the maternal organism A graphic presentation of some of the results is given in It will be seen that the deuterium concentration in the fetal fatty acids, as well as in the cholesterol, rose rapidly, and achieved half of maximal value in each case in about two days This indicates that about half of the fatty acids or cholesterol present in the fetus, at this stage of development, had been synthesized in the preceding two days Unfortunately, it is difficult to state with certainty, the extent to which this



synthesis occurred in the fetus, in view of the fact that we were able to demonstrate unequivocally the transplacental passage of both fatty acids and cholesterol. This demonstration hinged upon the feeding to the pregnant rat of isotopically labeled fatty acids in one instance and cholesterol in another. The abundant presence of isotope in the corresponding fetal products proved that these materials do cross the rat placenta from the maternal to the fetal side.

The synthesis of glycogen by the fetus has been studied by the same process (Fig 5) I shall not trouble you with the details of the mathematical analysis, other than to point out the rapid smooth enrichment of fetal glycogen with воторе From the shape of this curve we have been able to calculate that the rat fetus of this age manufactures each day a quantity of gly cogen equal roughly to the quantity that it contains If the fetus did not at the same time destroy glycogen this would lead to a daily doubling of its glycogen content. The fact that the glycogen content is increasing only about 40 per cent per day at this stage of development, indicates a rate of glycogenolysis of about 60 per cent of the synthetic rate

Per gram of tissue the quantity of glycogen which the fetus is making and destroying daily is impressively greater than the corresponding rate in the adult rat. On the other hand the rate of fatty acids synthesis by the fetus in com-



parable terms, is far slower than in the adult. It has seemed to me that these findings have an altogether reasonable meaning and I should like to present for your amusement my interpretation of them

When energy is to be stored for a protracted period in a living cell there appear to be two general processes available, both of which involve removal of a large, organic molecule from the continuous watery phase. The one is the gen eration of polysacchandes, such as glycogen or starch, the other the deposition of fat. In many simpler forms of life, polysacchande formation seem to be predominant, and indeed, there would appear to be little advantage in the storage of large fat depots in such forms Only when survival of the individual or of the species is dependent upon motility does a real benefit in the abundant storage of fat over carbohydrate If one stores fat in preference to poly sacchande, per calone stored one is required to carry around less than one half as much weight, and it follows therefore that, for a given caloric reservoir the fat-storing organism will be more motile than the polysaccharide storer

In the vegetable world one usually encounters vast carbohydrates stores and scanty fat stores. A striking exception is found in certain seeds like the cotton seed in which fat abounds. Sav ing of weight in such a seed is obviously of benefit to wide dissemination which in turn favors the survival of the seed and of the species. In the animal kingdom, in general one finds much fat and little polysacchande A striking exception is noted in mollusca, which are very rich in glycogen and poor in fat, but the mussel, other wise defended does not depend upon motility The rat, on the other hand, is a for survival very motile animal. Although his diet may be largely carbohydrate the material derived from that diet for storage is predominantly fat and

the rat's agility and his survival is, in some measure, the happy consequence of this fact. Were he to store glycogen isocalorically in place of fat, his weight necessarily would increase perceptibly.

Our findings in the rat fetus we take as a kind of biochemical atavism. In contrast to the adult, the fetus has proved to be fundamentally a glycogen-storing organism, resembling in this regard the vegetable forms. The rat fetus is like the common vegetables in other regards and of interest here is the fact that his survival is not dependent upon motility. He, further, has no need as yet for the thermal insulation and mechanical cushioning afforded by a subcutaneous layer of adipose tissue.

In the light of this discussion, the glycogen stores of the mammalian liver begin to resemble a Darwinian vestige. It is obvious that liver glycogen in the contemporary mammal does serve a function as a reservoir of energy and of glucose. It is a very small reservoir, however, and when it has been exhausted no drastic clinical change is demonstrable. If you will recall in the first figure, glycogen was situated as a cul-de-sac off the main line of reactions whereby glucose is burned to CO<sub>2</sub> and H<sub>2</sub>O, and I would suggest that it resembles that other cul-de-sac of wide repute, the vermiform appendix, in more regards than one

After this philosophic excursion, I should like to carry you back to the laboratory again. I have already pointed out to you how we have taken advantage of the relationship between the rise in deuterium concentration of glycogen and the rate of its turnover. There is another factor which determines in part the concentration of deuterium in any particular sample of glycogen, namely, the nature of the precursor. In Table 3 are collected data designed to show the nature of this relationship 4.5 Glycogen has, in each

TABLE 3 -- Deuterium Concentration in Liver Glycogen

Percentage of Body Water
38
44 35 33
35
33
43
43 43 56
56
57

case, been allowed to accumulate in the liver of the previously fasted rat, one or another glycogenic substance serving as precursor. The, point that I wish to make is that the formation of glycogen from small fragments, like lactate, results in the appearance of high concentrations of deuterium in the glycogen sample, when compared with glycogen formed from, let us say, glucose The reason for this is that only by chemical reaction involving the carbon-bound hydrogens is deuterium introduced into glycogen and more such reactions intervene between lactate and glycogen than between glucose and glycogen

An example of how this may influence expenmental results is seen in our study of the thiamin deficient rat 5 From the point of view of glvcogen synthesis, this animal presents two peculiarities In the first place, due to anorexia, probably less glucose is presented to the liver In the second place, due to the roles of thumin pyrophosphate in various enzyme systems. many normal dispositions of pyruvate are hindered, and the blood level of pyruvate rises experimental observation in the thiamin deficient rats receiving deuterium oxide was that whereas very little glycogen was found in their livers, what was found was about twice as rich in deuterium as the control value (Table 4) The glycogen that was laid down in the livers of the deficient animals apparently was made largely from pyruvate rather than glucose

TABLE 4 — DEUTERIUM CONCENTRATION IN LIVER GLYCO-GEN OF NORMAL AND THIAMIN DEVICIENT RATS

Normal Thiamn-deficient	Mg Glycogen per Liver 8 1 0 5	D Percentage of Body Water 18 7

Similar observations have been made on the action of adrenalin in the fasted rat. You will recall that whereas in the well-nourished animal, the major effect of adrenalin is to provoke a decrease in liver glycogen and a rise in blood glucose, in the fasted animal, deficient in liver glycogen, adrenalin administration is followed by an entirely different sequence of events Previous workers have shown a fall in muscle glycogen, a rise in blood lactate, and a secondary rise in liver glycogen They suggest that the liver glycogen that appears is formed from the lactate which the muscle discharges argued that in this event the liver glycogen should resemble isotopically that formed when lactate was fed and from the figures in Table 5 it will be seen that this expectation was gratified. As the Cons had postulated,7 it would seem that the

TABLE 5 — DEUTERIUM CONCENTRATION IN LIVER GLICO-GEN AFTER INJECTION OF ADDRESALIN

Treatment	D, Percentage of Body Water
Glucose Lactate	88 1 57 0
Adrenalin	56 <b>2</b>

glycogen appearing in the liver of the fasted rat in response to adrenalin is formed from circulating lactate.

The alterations that we have observed in the diabetic rat are indicated by data in Table 6 \*

TABLE 0

	PER Liver Gly- cogen	CENT OF I Carcass Gly cogen	DEUTERIO Liver Fatty Acids	Depot Fatty Acids
Allozan diabetes, glucose dist Phlorhisin poisoning	43 1 16 1	23 3 9 1	9 1 17 0	9 0 7 2

Despite the decrease in quantity of glycogen, the appearance of deuterium in glycogen of both liver and muscle proves that glycogen synthesis was still proceeding. The deuterium concentrations observed in these samples were, in fact, much higher than were found in normal rate after the same time interval, indicating that the glycogen deposited in the diabetic rats was being formed preferentially from small fragments rather than from glucose directly In the same animals. from the quantities and deuterium concentrations of liver and depot fatty acids it could be calculated that fatty acid synthesis was proceeding at only about 5 per cent of the normal rate. In others words, this particular fate of glucose lipogenesis, had all but stopped, and the 5 Gm of glucose which in the normal rat were consumed daily in this process were not utilized in the diabetic rat and contributed to the glucosuma

The liver fatty acids of the diabetic rabbit (Table 7) revealed a similar tendency 10

TABLE 7

	PER	CENT OF I	DEUTARIUM	IN
	Liver	Depot	Liver	Caross
	Fatty	Fatty	Glyco-	Glyco-
Treatment	Acids	Acid:	gen	gen
Alloxan diabetes	37	12	5.5	4.5
Allozan diabetes	14	i i	5.7	3 2
Normal control	6.6	0.8	<b>2</b> 8 C	4.6
Normal + insulin	26 1	2.3	8.6	3.7

Here again the deuterium concentrations were significantly below that of the normal control live fatty acid, indicating an impairment in the dia bette in hepatic lipogenesis. In the rabbit, in addition, we have been able to show the converse of this effect, something which to date we have not been able to show in the rat. The injection of insulm into the normal rabbit resulted in a marked increase in the deuterium concentration of the liver fatty acids, the value reaching 4 times the normal level and 10 or more times the diabetic level. This can only be accounted for postulating a tremendous increase in the rate of lipogenesis incident to insulin administration

The extra synthesized fat is, apparently, in part transported to the depots, as indicated by the rise both in quantity and deuterum concentration of the depot fat, and I should like to suggest that this stimulus to lipogeness may contribute to the weight gain observed when insulin is administered to underweight individuals.

When insulin is injected into the rabbit, a massive increase in the quantity of glycogen in liver and in muscle results. This glycogen, in both sites, is poorer in deuterium than that of the normal control which indicates that it has been formed fairly directly from glucose of the dist, without much opportunity for introduction of deuterium from the body water.

We have carried out several studies on the nature of the unnary glucose in these diabetic animals and Table 8 shows the type of results obtained.

TABLE 8

Urine Volume Gueose Gm Alloxan diabetes 281 14 2 Phlorihirin poisconing 24 3 3	Glucose Synthe- sised, Gm. 3 6	Glucose Synthe- sized, Per centage 5 4
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From a comparison of the deuterium concentration in the urine water and the urine glucose it is possible to estimate the fraction of all the glucose that was synthesized and the fraction that came directly from the diet. Because normal animals do not exhibit glucosuria, we have of course, no normal controls in this case. However, we have compared the calculated fraction of urinary glucose synthesized in the truly diabette and in the phlorhizinized rat, and from this it would appear that certainly no more, possibly less gluconeogenesis occurred in the diabetic than in the phlorhizinized rat.

Summary

I should like to allocate these effects with respect to the diagram presented in Fig 1 The diabetic animal makes glycogen, but the glycogen that he makes is excessively nch in deuterium and we postulate is made from small fragments. His ability to convert glucose directly into glycogen definitely is impaired Likewise he is almost unable to convert glucose into fatty acid Ample respiratory quotient data indicate an impairment of his ability to convert glucose into CO, and the atudies of others 11 suggest an inability to convert glucose into 3-carbon fragments

The administration of insulin in each case favors the utilization of glucose. As we have shown an abundance of fatty acid is synthesized.

TABLE 1

Name (Sex	ad after third
Name (Sex)         Age         Involved         Treatment         ment Begun         for Relief         Remark           1 FF (F)         52         D5         Severe         5 days         4         Rash failed to spre injection           2 AB (F)         26         L2         Moderate         10 daye         5         Pan decreased after tion           3 BC (F)         53         D4         Severe         5 days         5           4 MB (F)         50         D6         Severe         1 day         0         9 injections without vertebral 4 injection           5 IL (M)         54         D5         Moderate         2 days         3           6 RG (M)         54         C5 6         Severe         3 weeks         Patient failed to ret jections	ad after third
1 FF (F) 52 D5 Severe 5 days 4 Rash failed to spre injection 2 AB (F) 26 L2 Moderate 10 days 5 Paim decreased after the following severe 1 day 0 9 injections without vertebral 4 injections 5 IL (M) 54 D5 Moderate 2 days 3 Fatient failed to ret jections	
2 AB (F) 26 L2 Moderate 10 days 5 Pain decreased after tion  8 BC (F) 53 D4 Severe 5 days 5 4 MB (F) 50 D6 Severe 1 day 0 9 injections without vertebral 4 injections of the first plete relief  5 IL (M) 54 D5 Moderate 2 days 3 6 RG (M) 54 C5 6 Severe 3 weeks Patient failed to ret jections	er third injec-
4 MB (F) 50 D6 Severe 1 day 0 9 injections without vertebral 4 injections of RG (M) 54 D5 Moderate 2 days 3 6 RG (M) 54 C5 6 Severe 3 weeks Patient failed to ret jections	
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6 RG (M) 54 C5 6 Severe 3 weeks Patient failed to ret	
7 WB (M) 40 L1 Moderate 2 days 2	urn after 2 in
0 TO 100 10 10 10 10 1 1 1 1 1 1 1 1 1 1 1	
8 BL (F) 30 L2 Mild 4 days 5 3 injections stopped	i spread
8 BL (F) 30 L2 Mild 4 days 5 3 injections stopped 9 GC (F) 60 L2 Severe 14 days 5	• • • •
11 RC(F) 60 D4 Severe 16 days 4 injections with no	o relief
12 AJ (M) 35 D6 Severe 3 days 3	
13 HK (M) 21 D4 Moderate 3 days 2	
12 AJ (M) 35 D6 Severe 3 days 3 13 HK (M) 21 D4 Moderate 3 days 2 14 TG (F) 10 C4 5 Moderate 5 days 2  C4 5 Moderate 4 days 2 Recurrent (7) two 3 15 PR (M) 40 D4 Severe 7 days 2 16 RL (F) 35 D4 Severe 5 days 3 17 KG (M) 60 L2 Severe 12 days 6 Postherpetic neural	
C4 5 Moderate 4 days 2 Recurrent (7) two y	years later
15 PR (M) 40 D4 Severe 7 days 2	•
16 RL (F) 35 D4 Severe 5 days 3	
two months	lgin mild for
18 TJ (M) 45 L1 Severe 3 days 2	
19 RT (F) 15 D2 Severe 3 days 4	
20 SK (F) 22 D2 Moderate 3 days 3	
21 RS (M) 22 D3 Moderate 3 days 3	
23 FM (M) 65 C7, D1 Severe 21 days No relief after 4 inj	

although a relatively large concentration is required. It indeed may control cholinesterase activity, because of physical conditions or local concentration effects. Since the action of neostigmin is also postulated through its inhibition of cholinesterase, it seemed worth while to try a combination of these two substances instead of thiamin alone. Because of the excellent results obtained in our cases of herpes zoster, it seems probable that the addition of neostigmin to thiamin is a true potentiating effect.

# Method of Treatment

As soon as a diagnosis of idiopathic herpes zoster was established, 1 cc of thiamin chloride (100 mg per cc), and 1 cc of neostigmin methylsulfate (1 2000), in the same syringe, were given intramuscularly The injection was repeated every other day until the severe pain was relieved The number of injections required to induce relief varied Various factors were involved, as can be seen from the table. The age of the patient was very significant, since the older patients usually had more severe pain and were most apt to suffer postherpetic neuralgia In one instance (Case 4) no relief followed nine The pains became more severe paravertebral injection of the combined thiamin and neostigmin, placed at the corresponding dermatome, brought relief after the first injection of this type and complete relief followed four injections of this type Whether a local concentration was effective here is problematic 10

The duration of symptoms prior to treatment was significant in view of the results which showed that the earlier treatment was started the faster the recovery—There were several failures. The several patients who failed to return after a few injections also were classified as failures. Cases treated by the authors in previous years with nonspecific therapy such as narcotics, analgesics, local applications, and ultraviolet therapy were considered as controls in the evaluation of this new form of treatment—Of 20 such control cases, the average duration of symptoms persisted for approximately six weeks—In these cases, the pain was excruciating in the first ten days, despite the therapy

Six cases of neuralgia were treated by one of us, but these were not included in the table, since all four failed to develop the vesicles characteristic of herpes zoster. It is possible that these were preherpetic pains, since they presented themselves at a time when several other cases were seen. The results in these 6 cases were remarkably good.

## Comment

The remarkable response in our series of cases of herpes zoster makes it appear probable that the neostigmin aided in relieving the pain by potentiating the action of thiamin Neostigmin, however, may have a primary action of its own

# Summary

Twenty-three cases of idiopathic herpes zoster were treated by a combination injection consisting of 1 cc of thiamin (100 mg per cc) and 1 cc neostigmin methylsulfate (1 2000)

The results were sufficiently impressive to

warrant definitely further trial of this mode of therapy

1661 PROSPECT PLACE 1352 Carroli Streft

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# THE CARE AND EDUCATION OF THE TUBERCULOUS PATIENT IN THE HOSPITAL

The care of a patient in any institution is depend. ent upon the physical facilities of the hospital or sanatorium the proper balance of staff and the quality of the staff. An adequate budget is necessary but money is not the entire answer. A well-equipped sanatorium may still be a cold, unsym pathetic place. There must be an caprit de corps that starts at the top and carries through to every worker in the place.

The importance of a proper balance of staff is self apparent. There must be enough physicians enough nurses a satisfactory dictotic service, enough social workers, enough rehabilitation workers and enough accessory attendants to carry on the work properly

The quality of the staff will depend upon the training the experience and the personal interest of every person who takes part. Adequate salaries are necessary to attract and hold competent personnel.

There should be frequent and regular staff conferences not for the physician alone but for the entire administrative group the nurses social workers, and rehabilitation workers. Not only medical and surgical treatment, but problems of discipline, emotional instability and psychological approaches should be discussed. The staff should all learn to think as a unit. As a result, when a physician advises a patient and the patient asks the same question of the nurse or the social worker there will be agreement among them Some may feel that only a doctor should discuss medical subjects and that nurses social workers and others should always refer such questions to the doctor That is true if the answers are difficult, but no doctor ever loses prostige when his staff gives him informed backing and support,

In the treatment of tuberculosis the work of the doctor the nurse the social worker and the rehabilitation worker so dovetail that they are frequently helping with the same thing All four practice medicine in some way whether it be in troatment, care, or maintaining the proper mental equilibrium of the patient. All four do a certain amount of nursing service. All four may be drawn into the domestic problems usually handled through the social worker And all four take a part in re-babilitation. The direction and supervision of the work should be clean-cut, but the better the under standing, the more effective will be the cooperation between staff members

The other half of the work is the education of the patient which is carried on through personal contacts of the staff, talks and lectures, books and periodicals on tuberculosis, sanatorium publications, and visual aids of all kinds. The education of the patient

starts with the day that the diagnosis is made. Then the first shock is received and the patient s little world crumbles around him Often he loses everything for which he has worked saved and planned Usually he enters the sanatorium in a condition of mental chaos

It is the job of every person who is in touch with this patient to sympathize, to help to encourage and to gain his confidence. The hope and assurance of recovery must be instilled his family problems must be met and his rehabilitation started at this time.

At first the patient is too stunned to appreciate or understand the rules of the game, but his education must start right at the beginning. It is important that the attitude of every staff member should be that of a teacher giving the patient the hints and the rules which will be short cuts to recovery Opti mism should be the keynote.

When the first shock has worn off the patient is in the mood to be a pupil in our school for tuberculosis He will listen to other patients and get distorted ideas, he will listen to anyone and everyone. It is important therefore, that his information be

authentic.

The patient should be taught how tuberculous develops how it is diagnosed and how it can be provented. He should understand the different types of treatment and the objective of these treatments He should be made to realize that his cure is within He should be taught how the disease is himself spread and how to protect others. When this is done we have reduced the hazard nearly 90 per cent. The patient should realize the importance of followup examinations long after discharge. He should know the length of time that it takes before he will be well even after returning to a productive life. Too often the patient is discharged with a good prog nons from an institution but because his education has been incomplete, he becomes carcless and as a result has tuberculosis recurs.

The responsibility for patient education does not belong to doctors alone. It is the responsibility of every nurse every social worker and every rehabili tation worker who comes in contact with the patient The sanatorium should not be a jail but it should be a school for the education of the patient, and disci-pline is just as important as medication and treat ment. A well-educated patient who leaves the sanstorium with consent and is well on the road to recovery soldom breaks down again It is the careless patient who didn't learn the lesson who comes back to be readmitted .- Let a Improve the Care and Education of the Tuberculous Patient in the Hospital Howard W Bosworth MD, Transactions of the Vational Tuberculous Association, 1946

# CLINICOPATHOLOGIC CONFERENCES

FOURTH MEDICAL DIVISION OF BELLEVUE HOSPITAL, New York City

Date April 28, 1947

Conducted by Max-Wilhelm Johannsen, M D

# ADENOCARCINOMA OF THE CECUM WITH INVOLVEMENT OF THE LUNGS

DR WILLIAM A LEFF R K, a 42-yearold white man, was admitted to the Fourth Medical Division of Bellevue Hospital on January 17, 1947, with the chief complaint of a severe cough and chest pain of three months' duration and hoarseness for three days prior to He had had a "cigarette" cough admission from the age of thirteen, but this cough had become progressively worse during the past fifteen years manifested particularly by productivity of thick white sputum During the past three years his cough had been productive of about 500 to 800 cc daily, but was never bloodtinged or foul For three months prior to admission to the hospital, he had noticed blood streaking and small blood clots in the sputum There had been a 40-pound weight loss in the past He had worked very little during six months the past year because of his "run down" condition There had been no abdominal pain, vomiting, diarrhea, constipation, melena, or hematemesis Three days before admission he noticed hoarseness, marked weakness, a steady cough productive of blood-tinged sputum and pain in the chest

Physical examination revealed a patient who was chronically ill, pale with some cyanosis of the lips, emaciated, and dyspneic He coughed up blood-tinged sputum, complained of pain in the throat upon coughing, and was slightly hoarse The blood pressure was 120/70, respirations 28, pulse 100, and temperature 1015 F The conjunctivae were markedly inflamed The tongue was dry and beefy red The chest was symmetrical There was dullness in the left posterior axillary line with fine rales over the right middle lobe, and rhonchi throughout the entire The heart was not enlarged to percussion, there was regular sinus rhythm No murmurs were heard The second aortic sound was greater than the second pulmonic sound abdomen was soft, not tender, and no organs or masses were palpable There was no edema of the extremities

On admission the sputum examination was negative for acid-fast bacilli. A blood culture was reported negative. A complete blood count on the third hospital day showed 16,000 leukocytes with 84 per cent polymorphonuclears, 8 per cent lymphocytes, and 2 per cent monocytes. The red blood count was 3,340,000 with 9 4 Gm of hemoglobin

The patient was placed on penicillia therapy on the second day to which there was no response after forty-eight hours and sulfadiazine was started in its place Within two days the temperature fell to normal, but the patient appeared only slightly improved The sputum culture was reported to contain pneumococci which did not type, streptococci, Staphylococcus aureus, and hemolytic streptococci Examinations of the sputa were repeatedly negative for acid-fast On the sixth day the white blood count was 7,600, the patient appeared much less toxic and the amount of sputum had decreased His temperature remained normal for about three days, then commenced to rise slowly With this rise in temperature he was again given penicillin, both by aerosol and parenterally (40,000 units every three hours)

On the minth hospital day he started to vomit and could retain very little food. On this day one observer described a slightly tender elongated mass, "stony hard," in the right lower quadrant which "could not be indented with the finger" The vomiting persisted for the next four days and he was transferred to the Surgical Service on January 31, 1947 On the eleventh hospital day the white blood count was 11,200 with 80 per cent polymorphonuclears, 13 per cent lymphocytes, 3 per cent monocytes, and 2 per cent eosinophils The red blood count was 4,200,000 with 92 Gm of hemoglobin stool specimen for occult blood was reported as two plus A second sputum culture on the eleventh day showed pneumococcus (no type), Staph aureus, gram-negative bacilli (B coli), Str vindans After several days on the Surgical Service he developed cramp-like pains and vomited fecal material A Miller-Abbott tube was inserted and the patient was given two trans-He suddenly developed acute dyspnea and failed to respond to either oxygen or any other emergency measures His temperature mounted to 103 5 F and he expired on the seventeenth hospital day



Fig 1 Admission postero-anterior view of cheet showing bilateral abscerees with fluid levels and surrounding areas of pneumonning

Interpretation of X Rays —The admission film a posteroanterior view of the chest, revealed the bones and soft tessues to be normal (Fig. 1) There was some irregularity of the right diaphragm with cloudiness in the right costophrenic angle. The heart and mediastinum were normal In the left lung there was a cavity 21/2 inches from the hilus from the fourth to the aixth ribs antenorly measuring one inch in diameter with a fluid level, the upper margin of which was thin-walled, the lower and lateral margins appeared to be surrounded by areas of pneumonitis Extending out from the hilus there were soft infiltrations In the right lung one inch from the hilus there was a cavity at the third right rib measuring one inch in diameter which was thin walled with soft infiltration in the third, fourth and fifth interspaces In the lower third of the right lung there appeared to be several small areas of highlights and this infiltration extended down to the right diaphragm On January 29, eight days later the posteroanterior view showed the cavity to be one-half the size of the original description the wall was thin and the pneu monitis had somewhat subsided On the right the cavity was barely visible but there were several small areas of highlights surrounded by



Fig 2. Right anterior oblique view of the chest showing the empty cyst like cavities.

soft infiltrations The opacity described on the first film was still present but to a lessor degree. At the right bilus there was an irregular infiltration which seemed more opaque than the surrounding areas of infiltration in the lung

The right anterior oblique view showed either several cavities superimposed or a multilocular cavity with very tlun walls, measuring two inches in diameter and situated in the middle of the leftlung (Fig 2). The lower third of the posterior portion of the right lung showed several highlights surrounded by soft infiltration. The left an terior oblique showed a cavity in the lower third of the posterior portion of the left lung and infiltration throughout the middle portion of the right lung.

The barum enema showed normal filling of the large colon with little barum seen beyond the ileocecal valve (Fig 3) There were numerous large areas of gas apparently in the small bowel. One view showed a small amount of barium in the ileum which appears irregular

#### Discussion

DR MAX WILHELM JOHANNSEN If I may review the history it is stated that the patient had a cough for approximately thirty years and that in the last three years he rulsed 500 to 800



Fig 3 Barium enema showing filling defect at ileocecal junction

cc of a nonodorous, nonbloody sputum in twenty-Whether the daily sputum output four hours was measured or not, I do not know questionably, however, he raised large amounts This history suggests a chronic, bronchial catarrh resulting, probably, in chronic bronchiolitis, but I do not believe that it has any bearing on his present condition The latter reveals the Historically, the involvement of two systems pulmonary system manifests itself first by a severe cough and chest pain of three months' The history does not state where the duration chest pain was, whether it was localized or diffuse, its character, or what initiated it or relieved It states, however, that lately the sputum had become bloody, indicating an ulcerative The examination of the lung revealed process either the presence of some fluid in the left chest or consolidation of the lower left lung and evidence of pneumonitis in the right middle lung field

During the first hospital days, all symptoms and signs pointed to the respiratory tract and the response to sulfadiazine medication seems to indicate that the process was a pyogenic one and localized in the lung. When, however, on the minth hospital day, the second system involved in this case manifested itself, the entire picture changed. The patient began to vomit and a mass was felt in the right lower quadrant.

of the abdomen which, heretofore, had been normal to examination. Shortly afterwards, the patient developed signs and symptoms of low intestinal obstruction.

If we tried to correlate the pathology in this case with one disease, the differential diagnosis would be. I believe, mainly between tuberculosis and a malignancy Tuberculosis of the intestines occurs especially in the ileocecal region. and in a patient exhibiting evidence of obstruction due to tuberculosis, we ought to expect signs of a tuberculous peritonitis. This, the patient The pulmonary findings then did not have would be a manifestation of a chronic protracted lymphohematogenous dissemination and the patient would have run a more septic course With bleeding from the pulmonary tract indicating an ulcerative process, it would have been reasonable to assume the presence of acid-fast organisms in the sputum. The sputum was persistently negative for tubercle bacilli

The other possibility to account for the chest pain, namely, a malignancy with metastases to the lung and pleura seems more likely I would place the site of malignancy in the cecum because a carcinoma here is notoriously silent. Also, the diagnosis is frequently not made for as long as six months after the onset of symptoms pointing to another system It is not surprising, therefore, that the primary manifests first in the pulmonary tree, caused by the dissemination of carcinoma cells by way of the lymphatics chest pain, weight loss, low red blood count, and hemoglobin are of little value in differentiating between tuberculosis and malignancy Inasmuch as I had not seen the x-ray films of this patient until this conference. I presented the case the way it seemed to me to be reasonable with the data available

The \rays show fairly large-sized cavities in the left lung and smaller ones in the right lung with surrounding areas of pneumonitis colon fills well up to the ileocecal valve presence of cavities in the lungs confuses me and I am glad that I had no knowledge of their existence up to now because my speculations of a carcinoma of the cecum with metastases to the lungs would have seemed rather dubious Although metastatic nodules may break down and form small cavities, I think large-sized cavities are unusual but may well be present in bronchogenic carcinoma Nevertheless, the upper lung fields are clear and even now the picture is not that of tuberculosis There is no evidence of actinomy cosis which spreads usually by direct continuity rather than by blood stream, and I think I had better maintain my original impression of carcinoma of the cecum with metastases to the lungs

DR. MAX TRUBER The notation that this patient appeared acutely and chronically ill is apt in this case. There was a cough of in creasing seventy for over fifteen years with over one-half liter of sputum daily. He presumably had bronchectasis.

Within recent months there was blood streaking loss of weight, increased cough and eventually hoarseness. Except for cleest path there was no other systemic localization.

The physical findings over the lungs do not permit an interpretation Tuberculosis was never verified. There was a moderate anemna and an accelerated downhill course. I would suspect a pulmonary malignancy probably bronchogenic rather than metastatic because of the pre-existing bronchial pathology, and the final illness seemed to be an accentuation of previous symptoms.

The houseness apparently was not pronounced and was not further identified. It was too recent to be due to intrinsic disease of the larying, if there was cord paralysis neoplasm would be a likely cause for the recurrent laryingent nerve involvement. After one week he suddenly developed symptoms of acute intestinal obstruction a primary neoplasm would have given previous evidence of its presence. No mention was made of a mass or hernia on initial examination, the white blood count was normal preceding this episode.

Dr. Harry A. Solomov The case history indicates that this patient had respiratory symptoms since childhood. From the profuse expectoration bronchiectass could be inferred

With the insidious development of marked weight loss and weakness, another condition lad set in—chronic progressive and serious in character. A nonspecific superimposed respiratory infection alone could hardly explain his serious deterioration, yet the symptoms were exentially respiratory, the sputium showed only mixed progenic organisms and the physical signs in the chest were those of diffuse bronchitas with several scattered areas of parenchymal involvement. That the hearseness was due to laryngeal inflammation in their than vocal cord paralysis was suggested by the association of pain in the throat

The colon bacilli found in the second sputum culture was probably a contamination from the fecal vomiting rather than a fistulous communication between the lung and intestinal tract

As regards the acute abdominal symptoms with a tender mass in the right lower quadrant and intestinal obstruction with fecal vomiting the absence of pain should exclude mesentence embolism from the pulmonary vens intussus-seption, acute appendicitis or other acute

conditions from a more chrome lesion, either neoplastic or infectious

Whether the mass in the abdomen (with acute intestinal obstruction) is an independent lesson from the lung pathology is difficult to say. My final diagnosis is (1) childhood bronchiectasis, (2) multiple lung abscesses (3) embolic mesenteric thrombosis from pulmonary thrombophilelities and (4) possibility of neoplasm

Dr. WILLIAM A LFFF Dr Appelbaum, would you please comment on the importance of the gram-negative bacilli in the sputum?

DR. EMANUEL APPELBAUM The presence of the B coli in the sputum is not too significant in this case. One may find a super emergence of grain negative organisms after penicillin therapy

DR. ALLAN R ARONSON Was actinomy costs considered?

On WILLIAM A. LEFF The sputum was searched for sulfur granules, but none were found Cultures were likewise negative

Dr. Samull Myerson Granuloms should be considered as a cause for the involvement of the terminal fleum

Dr. Zachary Sagal There is nothing here to suggest a malignant process of the cecum There is usually chronic disease of the abdomen this is not the case here. The mass was discovered late and I believe this is an acute inflammatory condition of the terminal ileum not a neoplasm.

DR Cowin Boros The configuration of the barium enema does not conform to the usual expectation of a malignant process. It suggests an inflammatory or granulomatous process.

DR WILLIAM A. LEFF Dr Johannsen, now that you have seen the x rays of the chest and barium enema how do you correlate these findings?

Dr. Max Wilhelm Johannsen It is obvious that the patient had lung abscesses but mediastunal lymphadenopathy which I had expected to be present to explain the hourseness and wheezing is not seen. Although lung abscesses are not infrequently seen in primary carcinoma of the lung this would be the first instance in which I had seen lung abscesses in metastatic lenons. The barium enema, however still is entirely consistent with carcinoma of the cecum It is well known that carcinoma of the cecum is not always visualized even by careful examination Actinomycosis is unlikely because it is always spread by direct dissemination, hemntogenous spread is rare I think that I had better maintain my original impression of carcinoma of the cecum with metastases to the lung and pleura

Clinical Diagnosis Caremonia of cecum with metastases to lunes

# Presentation of Pathology

DR HENRY SPITZ The anatomic diagnosis n as

Adenocarcinoma of Cecum with Direct Extension anto Adherent Loop of Ileum, Necrosis, and Perforation

Fecal abscess, retrocecal, perforated Acute diffuse peritonitis Paralytic ileus, clinical Secondary carcinoma in diaphragm, pleurae, and pulmonary lymphatics Pleural effusion, bilateral (100 cc)

Secondary Carcinoma in Lungs with Central Necrosis and Capitation

Congenital anomaly of kidneys-Horseshoe

At autopsy the body was found to be that of a well-developed but thin, middle-aged, white The mucous membranes of the mouth were pale

On opening the abdominal cavity, all of the visceral and parietal peritoneal surfaces were markedly congested and covered with a thin laver of fibrin The peritoneal cavity contained 500 cc of light brown thick fluid with a fecal The loops of the small intestine were dilated and filled with gas A firm, whitish mass of tumor tissue was seen to involve the cecum which was fixed to the anterior abdominal wall by thick fibrous adhesions, also, a loop of the ileum and the omentum were adherent to the cecal mass On dissection the tumor mass was found to be hard, and nodular, involving the The mucosa over the wall of the entire cecum tumor mass was ulcerated and bleeding and the mass constricted the lumen of the cecum and first portion of the ascending colon to a diameter of 15 cm

A loop of ileum 20 cm from the ileocecal valve was adherent to the cecal mass and the neonlasm had extended into the ileum without reaching the mucosal surface The wall of the cecum was perforated at its lateral aspect The perforation communicated with a retrocecal abscess that had perforated medially and behind the cecum into the peritoneal cavity. The other abdominal organs showed no important changes except for the kidneys The kidneys joined together at their inferior poles to form a "horseshoe" type of There was a slight dilatation of the right kıdney renal pelvis

On opening the thoracic cavity a few fibrous pleural adhesions were found in each pleural cavity There was 100 cc of pinkish, serous fluid in each pleural cavity and the parietal pleural surfaces were smooth and glistening

The right lung weighed 720 Gm and the left lung, 620 Gm The pleural surfaces of both lungs were studded with numerous, small white nodules some of which were connected by thin white cords in the pleum. On section, several firm roughly spherical, whitish masses of tumor tissue with soft necrotic centers were seen in each line These masses varied from 2 to 8 cm in diameter. two of the largest tumor masses were located in the lower half of the left upper lobe beneath the pleura, they had eroded into the bronch and cavities were formed by the loss of the necrotic centers The remaining lung parenchymashowed slight congestion and edema The bronchi contained a mucopurulent exudate The hilar lymph nodes were small, firm, anthracotic, but showed no gross evidence of neoplastic invasion The diaphragm was studded with small, firm, white nodules of tumor tissue measuring 3 to 7 mm in diameter

The heart, bone marrow, neck organs, and pelvic organs showed no important gross changes

Microscopic examination of the mass involving the cecum showed adenocarcinoma, extensively ulcerated, extending through all the layers of the bowel wall On the outside of the cecum there was an extensive, chronic, organizing, inflammatory reaction The diaphragmatic nodules were composed of adenocarcinoma identical with that seen in the cecum Sections of the lungs showed that the perivascular, peribronchial, and subpleural lymphatics were extensively invaded by tumor cells resembling those seen in the cecum In many areas the tumor cells invaded the walls of the bronchi and spread into adjacent lung parenchyma using the intra-alveolar septa as stronal scaffolding In some areas extensively involved by the adenocarcinoma, there was central necross of tumor tissue. The noninvolved portion of lung showed edema, moderate emphysema, and in one area a small patch of organizing pneumonia

# Summary

This was a case of secondary carcinoma in the lungs with central necrosis and cavity formation with the primary adenocarcinoma in the cecum Extension of carcinoma from the cecum to the lungs is uncommon, and cavitation of secondary carcinoma in the lungs is extremely rare ever, in this case the metastatic neoplastic type of the lung lesion suggested itself clinically by the following points a palpable mass in the right lower quadrant of the abdomen, cavitation of the lower half of the upper lobe, and consistent failure to demonstrate acid-fast bacilli in the sputum

#### LATERAL WALL INFARCT IN THE BASAL REGION OF THE LEFT VENTRICLE

STEPHEN MAJOR, M.D., Binghamton, New York

A CASE of coronary occlusion is presented because nonspecific electrocardiographic abnormalities in the standard leads were accompanied by such unequivocal clinical and laboratory findings that the diagnosis of infarct was made from the very onset. Later, a series of chest leads not only proved the existence of an infarct, but also throw some light on its possible location.

#### Case Report

The patient, L. S, is a 48-year-old hospital employee whose family history reveals the death of his mother and one of his brothers of pulmonary tuber He suffered pneumonia when two years old and a right upper cervical gland absects at four the time he was ten years old he also had had chicken pox and measles. He grew very fast, was gracile and easily fatigued. At cloven he had chorea minor of two months' duration and 'flu when eighteen. A year later he joined the merchant marine and was discharged after almost four years service for bronchitis. Since that time he has been susceptible to colds and has had three attacks of grippe.

In January 1945 he called on the writer complain ing in vague terms of easy fatigability and general He appeared to be a robust man & feet, 11 inches tall, and weighed 205 pounds. On exami nation, the lungs were clear and the heart was not enlarged, but on auscultation a soft systolic murmur was heard at the apex, evidently a residual of the chorca. His blood pressure was 180/90. He was advised to lose some weight.

Six months later he again complained of pain in his calves Otherwise, he felt all right and had lost 20 pounds his blood pressure was 170/80 his blood sugar was 90 mg per cent. He was advised to

increase his sugar intake.

On January 2 1046 he was hospitalized for an upper respiratory infection, and with sulfa medication recovered in about a week. About ten days after his discharge he complained of being 'all in and of tightness in his chest, restlessness and in somnia An electrocardiogram was taken on Janu ary 22 1046 (Fig. 1) which revealed a deep Q, and a diphasic T, interpreted as possible readuals of an carlier undiagnosed coronary occlusion. The com plaints had some neurotic coloring but the presence of coronary disease was duly considered Sedatives were given.

On January 23 1046, this patient again returned now with the complaint of malaise and difficulty in swallowing. His temperature was 100 F., and on examination a fairly large bulging of the left pharyn-geal wall was found, without any ovidence of fluc tuation Sulfa medication was immediately started and in the evening his temperature rose to 103 F However he made an uneventful recovery in five

days.

Hardly a week had passed when the patient telephoned that for the last two nights be had experi enced distress in his chest, difficulty in breathing, cold perspiration, and anxiety He was advised to outer the hospital, which he did the next morning In the hospital (February 5 1946) examination

revealed dyspnea, slight cyanosis congestion of the base of the lungs, enlargement of the heart and harsh, diffuse systolic murmur loudest over the pulmonary ares. The blood pressure was 158/96, the temperature was 99 6 F the pulse rate 96, the rhythm was regular the respiratory rate was He received emergency treatment for coronary occlusion with signs of decompensation.

The laboratory findings were urinalysis, negative the blood showed a hemoglobin of 70 9 per cent, red cell count 4.08 million, white cell count 15,050 with 76 per cent polymorphonuclears the sedimentation rate (Westergren method) was 6.22 48-64 in an hour, the nonprotein nitrogen was 24.8 mg per cent, the sugar was 82 6 mg per cent the Wassermann was negative. An electrocardiogram, taken in the afternoon showed changes in the Q wave in the third lead its voltage increased from two and a half millivolts to 5 millivolts. The T wave in the third lead was still diphasic, and it was expected to undergo characteristic changes within hours (Fig. 2) Retinal examination was negative.

During the day his condition did not show much change. He breathed with considerable difficulty was tired, and occasionally coughed up thick mucus. Toward evening his face, hands and feet became pufly and edematous. The temperature was 100 F Ho still had a tight feeling in his chest. At 2 A M (February 6 1046) he had an attack of severe precordial pain radiating toward his left shoulder increased dyspines cyanoels, and cold perspiration.
The next twenty four hours were characterized by exhaustion and dull pain in his left chest. The tem perature was 100 6 F pulse rate 86 respiratory rate 24 blood pressure 100/110 The sedimentation rate went up to 75 mm. in an hour The white cell count was 13 300 with 75 per cent polymorphonu The white cell clears.

The next day he was essentially the same except that does of ammophy llin increased his diuresis and he was less dyspneic. The temperature was 100.8 F During the night however the precordial pain became so severe that opiates again were necessary On February 8 he was comparatively quiet, but on the minth the chest pain and dyspines increased and blood-tinged sputum appeared. That night the patient again had an attack, during which the respir









بمعتونة أعر

Fra 1



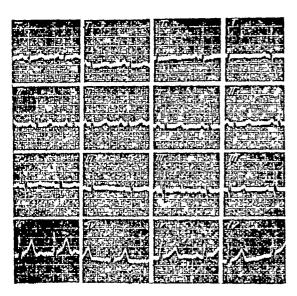


Fig 3

atory rate was 40, irregular, much anxiety was experienced The following day the sputum was

still blood-tinged

On February 11 an urinalysis revealed three plus albumin, many erythrocytes, and a few granular casts. The white cell count was 22,500, and the sedimentation rate was 94 mm in an hour. No doubt renal infarcts, possibly due to emboli, were completing the picture. From that time on the patient's clinical condition gradually improved and after eight weeks of hospitalization, he was discharged on April 2, 1946. His blood pressure, which also gradually diminished was 116/80 on that day. But, while he improved clinically, the laboratory findings were for a long time abnormal.

Between February 15 and March 29, six white cell counts were done, gradually decreasing from 13,400 to 6,600 During the same period seven sedimentation rates showed a decrease from 55 mm to 38 mm in an hour. Also, seven urinallyses revealed a specific gravity between 1,020 and 1,025, occasional albumin was present and, in the sediment, a few red cells, epithelial cells, hyalin, and epithelial casts were always present. On March 28, an x-ray of his chest showed no enlargement of the heart and the lungs were negative. Twenty-five days after his discharge the sedimentation rate was still 27 mm and there was albumin and a few hyalin casts in the urine. On May 23, finally, the urine was negative, the white cell count was 7,100 with 64 per cent polymorphonuclears, and the sedimentation rate was 14 mm

The electrocardiographic tracings taken during the illness, the convalescence, and after his discharge, at a 10-milly olf standardization, showed the

following

An electrocardiogram taken February 6 was, in all particulars, equal to the one in Fig 2. The day after, the tracing revealed an increased voltage of Q<sub>1</sub>—it was 6 milivolts—and T<sub>4</sub> showed some tendency toward elongation. There were no further changes on February 9, the fourth day of hospitalization and the day of his third attack. On February 11, however, changes, though not the expected ones, occurred. There was a slight depression of the ST<sub>1</sub> segment and a slight, elevation of ST<sub>4</sub>, both already noticeable on the previous tracing, a flattening of T<sub>2</sub> and the deepest Q<sub>2</sub> ever registered in this case

it was 9 millivolts. Two days later the tracing showed a flattening T<sub>1</sub>, a deep S<sub>1</sub>, while Q<sub>2</sub> was only 6 millivolts. On February 16 T<sub>1</sub> appeared only as a tiny elevation, while Q<sub>3</sub> regressed to 4 millivolts (Fig. 3)

Then, no remarkable changes occurred in the following four electrocardiograms, taken during the rest of his stay in the hospital, except for a more evident T<sub>1</sub> and some fluctuation in the voltage of Q<sub>1</sub> be-

tween 4 and 5 millivolts

On April 2 the patient was discharged and went away for a vacation. He returned for a check-up on April 24, at which time his electrocardiogram showed a fairly good T<sub>1</sub>, a diphasic T<sub>3</sub>, resembling the first tracing in Fig. 1, but it still showed a quite prominent Q<sub>3</sub> of 5 millivolts. A check-up a month later resulted in the same pattern. After he had worked for another month, with some fleeting sensation of chest distress, an electrocardiogram was taken on June 20, which showed a flat T<sub>1</sub>, while Q<sub>4</sub> and T<sub>4</sub> were exactly the same as in Fig. 1

Of course there was never any doubt in the writer's mind that this patient suffered one, or even two, coronary occlusions during his recent illness, and he expected the development of changes characteristic of a posterior and an anterior wall infarct. When these electrocardiographic changes did not occur, he thought, no doubt somewhat late, to investigate

possible other localizations of the infarct

On July 30 an electrocardiogram of standard leads plus chest series was taken. The patient had been working then for almost three months and for the last month had been completely symptom-free The chest series consists of seven leads, the first being at the fourth interspace on the right sternal margin, the last at the intersection of the posterior axillary line and a horozintal line drawn from the CF<sub>2</sub> position. Then five high chest leads were taken on a horizontal line starting at the CF<sub>2</sub> position and going to the posterior axillary line. These five high chest leads correspond, on a longitudinal plane, to CF<sub>3</sub> through CF<sub>7</sub>

In Fig 4 the standard leads show a completely upright T<sub>1</sub>, Q<sub>2</sub> is 4 millivolts, T<sub>3</sub> is diphasic, as in Fig 1 In the chest leads CF<sup>1</sup> <sup>2</sup> show a large upright T wave In CF<sup>4</sup> the T wave is upright, but less large, in CF<sub>6</sub> the T wave is barely visible and in

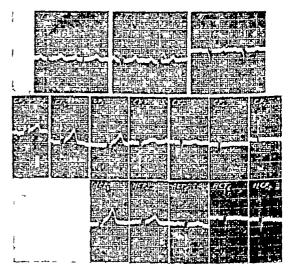


Fig 4

CF, the T wave is flat and sometimes almost inverted In the high chest leads the HCF, has a very large T wave, in HCF, the T wave is less large. In HCF, the T wave is upright but small, and in HCF, the T is slightly inverted

#### Conclusion

This patient presented a clinical picture of acute coronary occlusion and yet on the four standard electrocardiographic tracings he had only nonspecific abnormalities of which the most remarkable was the steadily increasing voltage of Q<sub>i</sub>, to a point where it was 9 millivolts while the largest deflection of that particular tracing was an R<sub>1</sub> of 23 millivolts (Fig. 3) The writers expectation was that of an at least late inversion of T<sub>2</sub>, though at times the minimal changes of T<sub>1</sub> made him think of anterior wall involvement. It was also suspected that the infarct might be in the interventricular septum, however in that cose interventricular conduction defects should have appeared

It is most unfortunate that chest lead series were taken only seven months after the attack and so the deep T inversions were missed however those T

wave inversions which were observed in the high chest leads of the axillary region appear to the writer typical evidences of infarction although they appear in a recovery stage and, at a time when all signs of abnormalities in the standard leads returned to preinfarction stage.

As far as localization is concerned it is felt that the infarct was in the basal region of the left ventricle states well.

This patient also suffered renal infarctions which most likely were due to embol. It is possible that the blood tinged sputims were due to pulmonary embolism of which the mechanism would be obscure

#### Summary

The clinical course of a typical myocardial infaret is reported with nonspecific abnormalities in the standard electrocardiograms outstanding of which was an exaggerated Q deflection. Later chest lead series localized the infarct in the basal region of the left ventricles lateral wall. The patient suffered renal embolism and possible pulmonary infarction.

#### PREVENTIVE PSYCHIATRY VIEWED REALISTICALLY

Fundamental changes in attitudes, which can come only from within the medical profession itself are vitally needed in the field of preventive peychiatry, according to Dr. Ralph M. Kaufman chief psychiatrist Mount Sinai Hospital, New York City Bpeaking at the recent Institute on Public Health.

Speaking at the recent Institute on Public Health of the New York Academy of Medicine Dr Kauf man spotlighted "realties" in proventive psychiatry from the standpoint of "The Adult. He focused on the need for a revamping of fundamental medical education—not in terms of increasing the number of bours for psychiatry as such, but in opportunity for centegration of the psychologic with the somatic an ideal and practical medical curriculum which would lead to the graduation of dectors willing and able to practice comprehensive medicine would be one of the most valuable contributions which could be made in the fold of preventive psychiatry psychiatry.

be made in the field of preventive psychiatry.
He underscored the dearth of facilities for psychiatric treatment and the tremendous need for
training of additional social workers and psychologate who will participate within their functional
limits in treatment programs. He recommended

that every general hospital, regardless of its sate have a psychiatric department not only for diagnosis evaluation, and treatment of frank psychiatric problems, but also to act as a center within the hospital for the education of all other staff members and personnel in the recognition of the importance of psychologic factors in all illness.

Looking at realities from the standpoint of "The Adolescent, Dr Milton J Senn, associate professor of pediatries in psychiatry, Cornell University Medical College said that one who focuses infant care practices soon comes to the realisation that attempts toward prevention and correction must be directed toward work not with the infant or young child but with his parents. Education of anyone clse, he said will be most productive of opportunities are provided when the persons to be taight are most receptive to learning about parent hood. Such an interest comes naturally in addlescence Education and guidance of the adolescent offers real and practical opportunities for prevention in psychiatry —Health News June 2 1847

Every Sunday the papers contain articles telling all sorts of ways to prolong life. They seem to forget the year of keeping away from the front of automobiles and the rear of mules and the need of leaving 'unloaded pistols ngidly alone. They all

agree that kissing is unhealthy, but did you over know a couple to kiss for their health? Of course it is true that a man can catch things from kissing notably matrimony—Da Costa Clinical Medicine June 1947.

# MULTIPLE, PROGRESSIVE, ACUTE ARTERIAL OCCLUSION, ASSOCIATED WITH HYPERTHYROIDISM AND DIABETES MELLITUS

HERMAN B ZURROW, M.D., and GAMLIEL SALAND, M.D., New York City

(From the Medical Service of the Bronx Hospital)

THE simultaneous occurrence of severe peripheral arterial disease, hyperthyroidism, and diabetes mellitus cannot be as rare as we may infer from the paucity of such reports in the literature. The following case demonstrates the almost inevitable consequences resulting in tissues whose metabolism has been raised to abnormal levels, while an impoverished blood supply fails to deliver the essentials necessary to maintain that metabolism. The increase in tempo of the development of gangrene in this case is sufficient to justify the adjective, malignant.

# Case Report

MS, admitted April 17, 1940, 44 years old, a European émigré, was, according to his own statement, very well until the onset of his present illness Close questioning, however, disclosed that for the past year and a half, the patient had noted some irritability and fatigue on slight exertion. There had also been a gradual loss of weight of approximately twenty pounds, an excessive thirst, an increase in urinary output, and excessive perspiration even without exertion or evposure to warm environment. There were absolutely no symptoms of intermittent claudication, rest pain, coldness, paresthesias, or color changes of the extremities.

Five days before hospitalization, the patient had been suddenly awakened by a severe pain in the right foot and toes. An attempt to stand and walk produced even more pain, and, in addition, blanching of the foot. He had been treated at home with sedatives and bed rest until glucosuria had been discovered, whereupon he had been hospitalized.

On admission, he had a slight pyrevia, a pulse rate of 110, a hot, moist skin, a fine tremor of the hands His eyes had a definite stare, the palpebral fissures were wide, winking was infrequent, hid lag was present, well-marked arcus senilis existed, the pupils reacted promptly The thyroid lobes were moderately enlarged but neither a thrill nor a bruit The heart was enlarged downward and to the left, sinus tachycardia was present, the sounds were of good quality, a soft apical systolic murmur was heard, the aortic second sound was loud, the blood pressure was 190/80, the lungs were normal, the abdomen was normal. The right lower extremity was cold from the ankle down, and was pale except for two small areas on the dorsolateral surface of the foot, and the fourth and fifth toes, which were cyanotic There was no loss of toes, which were cyanotic There was no loss of motion in the ankle or toes, and sensation was intact. The right femoral, popliteal, and posterior tibial arteries were palpable, and graded 4+ for patency. The right dorsalis pedis pulsation was not been applied to the patency. patency The right dorsalis pedis puisation in a felt. The left lower extremity was normal, all arterial pulsations were palpable and graded 4+ for patency. The admission diagnosis was exophthalmic goiter, diabetes mellitus, and acute arterial occlusion in the right leg, below the bifurcation of the

It was concluded that the occlusion was thrombotic in character since there was no likely source of

-

origin of an embolus Blood dyscrasia was ruled out as an etiologic factor for thrombosis. Serum coagulability was normal

The patient was placed on routine therapy for thyroid intoxication, diabetes mellitus, and arterial occlusion, including elevation of the head of the bed, heat to the upper extremities to produce reflex vasodilatation in the extremities, antispasmodics, including whisky, intravenous papaverin HCl, a paravertebral block of the first, second, and third, right lumbar sympathetic ganglia, pavex therapy, and protection of the limb by cradle and soft wrapping

Laboratory findings included a fasting sugar of 222 mg per 100 cc blood, 1 5 per cent sugar in a twentyfour hour urine specimen, a 2+ acetone A basal metabolic rate was +84 Wassermann and Kahn metabolic rate was +84 tests were negative Urea nitrogen was 154 mg Uric acid was 6 1 mg Creatinine was 1 37 combining power, three days after admission, was 54 8 Prothrombin time on admission was 86 per Serum coagulability test (Nygaard and Brown) was 200 seconds Bleeding time was one and one-half minutes, coagulation time was six minutes Blood count gave 94 per cent hemoglobin, 4,900,000 red blood count, 13,300 white blood count, 76 per cent polymorphonuclears, 23 per cent lymphocytes, 1 per cent monocytes Blood culture was negative after one hundred and forty-four hours Electrocardiogram confirmed sinus tachycardia and disclosed a notched T<sub>2</sub> and diphasic T<sub>4</sub> Roentgen examination of the chest disclosed no abnormality of the heart and lungs and no evidence of substernal thyroid enlargement Roentgen examination of upper and lower extremities disclosed no calcufer-tion of blood vessels The paravertebral block re-sulted in a rise of 0 6 C in the skin of the dorsum of the right big toe

On the afternoon of the second hospital day, the right posterior tibial artery pulsation could not be palpated. In three days the diabetes was adequately controlled. The patient was taking Lugol's solution and was comfortable. On the morning of the third day, the patient experienced a sudden, severe pain in the left big toe and foot, entirely similar to that experienced in the right a week before. Examination disclosed absent pulsation in the left dorsalis pedis artery, and diminished pulsation in the left posterior tibial artery, but normal pulsation in the populteal and femoral arteries, coldness and pallor of the toes and foot were present. A diagnosis of acute arterial occlusion due to thrombosis in the arteries below the populteal bifurcation in the left leg was made. A left paravertebral block of the first, second, and third lumbar sympathetic ganglia was performed, and pavex therapy started on the left leg. The following day no pulsations were palpated in the left posterior tibial artery.

The course of the patient's illness now became stormy. Despite therapy, gangrene developed and spread rapidly in both lower extremities. By the end of the third hospital week, it extended from the toes to four inches below the knees on both sides. Thereafter, it spread more slowly until the patient died seven days later. The diabetes was controlled

Both poplit

for the first two weeks of hospitalization. At that time the patient experienced a thyroid storm. Thereafter the diabetes became uncontrollable Surgery was not attempted because of the poor condition of the patient. Roontgen therapy to the thyroid could not be given successfully because of disorientation and lack of cooperation of the patient. Lugol's solution and quinine failed to affect the thyrotexicosis. The patients condition deterior ated rapidly. He formed a pitiable picture sitting with his gangrenous limbs in tallor fashion tearing off whatever wrappings were placed on the limbs constantly moving his body muttering, his ever stang out of a cadaverous face. Finally be lapsed into come and died thry days after hospitalization

The postmortem findings were as follows The

cal arteries were thickened and a section contained

femoral arteries were grossly normal

thrombi which completely occluded the vessels section, the thrombi were firm and reddish-vellow and extruded below the popliteal bifurcation into the tiblal artieries. The posterior tilhal arteries were occluded by thrombi from the bifurcation to their termination The anterior tibial arteries were not occluded The veins were normal Microsconi cally, the right popliteal artery disclosed advanced sclerotic changes there was splitting of the internal elastica The left poplitenl artery showed marked subintimal proliferation with some irregularity in the internal elastica, and some fraying and reduplica-tion there was considerable medial degeneration. The left posterior tibial artery showed some sub-intimal proliferation the remainder of the vessel wall appeared normal. This was also true in the right posterior tibial artery. The right antenor right posterior tibial artery. The right anterior tibial artery showed marked fraging and reduplica tion of the internal elastica. Grossly and micro-scopically the heart was normal. The aorta was the scat of moderate atherosclerosis. The thy rold was fibrotic, reddish yellow on section, homogeneous, and firm Microscopically the acini were well filled with colloid except in scattered areas where they were devoid of colloid or contained material that did not stain that did not stain Grossly the pancreas was nor mal, but microscopically there was seen a fine dif fuse interstitial edems with some fibrosis. Many of the isles of Langerhans seemed atrophic. The spleen was enlarged, and microscopically an unusual degree of reticular cell hyperplasia was seen. The liver was the seat of congestion and cloudy swelling. The kidneys were normal. The lungs were normal The esophagus and stomach were normal Meckel a diverticulum was demonstrated as well as two jojunal intussuceptions. The bladder mucoes had several hemorrhagic areas. The anatomic diagnosis was bilateral dry gangrene of both lower extremuties, thrombosis of both poplitical and posterior tibual arteriors, fibrotic thyroid, arteriorederosi of the aorta, Meckel's diverticulum, two jojunal intussusceptions hemorrhagic cystitis and pul monary edema

#### Comments

This case provokes speculation The relationship between arteriosclerosis obliterans and diabetes mellitus is well known. Arteriosclerosis obliterans occurs more frequenth and at an earlier age in diabetics. Gangrene is usually precipitated by infection to which the diabetic is so prone and the spread of gangrene is notably influenced by the extent and severity of the infection and the state of the arterial supply. In this case infection was not present.

What role did thyrotoxicous play in relation to the diabetes and arteriosclerosis obliterans in this case? The pathology in the affected arteries appears sufficient to account for the thromboes under ordinary circumstances, but the tempo of the spread of gan grene seemed excessively rapid and wo were at a loss to explain this phenomenon. We have watched the development of gangrone in many instances but in occase had we seen such rapid death of tissue. The question then arose as to what caused this rapid spread and what relationship the hyperthyroid state had to this increased tempo.

It is a known fact that metabolism of tissue is increased in the hyperthyroid state and that increased metabolic demand of necessity requires increased blood supply to tissues. In a patient with already diminished blood supply due to the arteroscierous such an increased demand for blood would certainly not be met. It is conceivable therefore, that cells would die if this increased blood supply would not be delivered and endothelial tissue is as susceptible as any other tissue. Under such conditions death of endothelial tissue would hasten the tendency to thrombosis formation and the more rapid development of gaugrene

#### Summary

A case of acute arterial occlusion in both lower extremitics is presented, in association with diabetes mellitus, arteriosclerosis obliterans, and thyrotoxcosis. It is suggested that the hyperthyroid state increased the tempo of the pathologic process to justify the description of malignant gangrone.

36 West SOTH STREET

## ANNUITIES FOR PHYSICIANS

The physician generally makes a comfortable in come, brings up his family, but provides very little for his declining years. This is painfully and in creatingly evident under our present tax situation which permits the physician seanty opportunity to save. In most corporations, pension systems have been set up for the protection of their employues when they reach the unproductive years. The money so invested is deductible on the part of the corporation. We apparently have no such escape for money so set aside, even if we use it to buy an annuity. The chairman of our Committee on Public Relations has been studying this problem for

the past year Even if we cannot persuade our Washington legislators to write in a deduction for annulties for physicians and others in similar circumstances, many of us feel that in any case the Society should endeavor to work out a group annuity program for its members such as might be available at a lower rate than one could obtain as an individual Such a project if successful, might become a major item in the economic program of your County beceiv

-trom the President's Address Dr William C White New York County Medical Society May

26 1947

# WHAT THE NONPROFIT MEDICAL CARE PLAN MEANS TO THE DOCTOR AND THE PUBLIC

GEORGE P FARRELL, New York City

(Director, Bureau of Medical Care Insurance, Medical Society of the State of New York)

IN ORDER to evaluate the benefits of a voluntary nonprofit medical care plan to the doctor and the public, certain basic principles must be considered

The choice rests with the subscriber to voluntarily protect himself and his dependents against unpredictable catastrophic costs of medical care. The plan provides free choice of physician, it guarantees that no restriction is placed on the doctor-patient relationship, it provides liberal benefits consistent with sound underwriting practices on a nonprofit basis, it eliminates any third party interference in the administration or benefits offered. The term "benefits" means cash paid by a plan to a participating doctor for services rendered a subscriber and dependents.

In a short period of time evolutionary changes have taken place in the distribution of medical care costs through the facilities of medical care In 1940 only a few were in operation but at the present time throughout the United States there are approximately eighty plans sponsored by county and state medical societies and covering about five nullion people There are only two states which have no plan or one in the process of formation The acceptance by the public of the benefits offered through nonprofit voluntary medical care plans, since their inception, is evidence that the average citizen, who finds it difficult to meet unexpected and unpredictable medical care costs, has found a means to protect himself and his family

Six plans sponsored by county and state medical societies with a membership of more than 700,000 are now operating in New York State. The increase in membership during 1946 exceeded 329,000 or 122 per cent over all previous enrollment. It is reasonable to assume that membership during 1947 will increase to a million in New York State and benefits will exceed \$3,500,000.

With over 15,000 physicians throughout the state participating in the plans, the doctor-patient relationship is maintained. That relationship is a very personal one, based not only on trust in professional ability, but on many psychologic factors of intangible value to the well-being and recovery of the patient. You can choose

Presented by invitation at the 141st Annual Meeting of the Medical Society of the State of New York Buffalo May 9 1947 General Sessions your doctor on this time-honored American system, and I choose mine, a privilege which cannot be denied or interferred with in the practice of good medical care. This has been a contributing factor in making us the healthiest nation in the world.

Under the proposed National Compulsory Insurance Plan, it is certain that controls would be necessary, both as to the manner in which the physician could practice and the conditions under which the people could avail themselves of medical services How far-reaching these controls would be has not been clarified that the Surgeon-General would administer the program under the supervision and direction of the Federal Security Administrator controls which are set up under such a national compulsory plan will alter or destroy the doctorpatient relationship as we know it today patient will be taxed for a service whether he uses it or not, and if the choice of his own physician is desirable, he may often also pay privately for his services In all countries where the doctorpatient relationship has been destroyed, either wholly or in part under compulsory programs, the costs of medical care have consistently increased and the quality has deteriorated

The plans now in operation provide to the subscriber liberal benefits for premiums charged, and, as experience warrants it, benefits are increased consistent with sound underwriting practices

In New York State during 1946 the subscriber and members of his family used the services of a doctor on more than 95,000 occasions, for which benefits were received in excess of \$2,000,000 These benefits represented payment by the plan to the physician for medical care rendered They were equivalent to 1,000,000 office calls at \$2.00 per call, 40,000 tonsillectomies at \$50, or 20,000 appendectomies at \$100

The plans make it possible for the subscriber to budget for unpredictable medical costs in advance and future income need not be mortgaged to pay for catastrophic illnesses

The physician is guaranteed payment of his bills according to an indemnity schedule agreed upon. This amount is used as a credit toward his regular fee, if it is greater than the indemnity allowance, for subscribers who do not qualify for service benefits. There is no additional charge

to subscribers who qualify for benefits under a service contract

Service contracts are available in some plans for the individual subscriber whose income is not in excess of \$1,800, while other plans provide service benefits where the individual income does not exceed \$2 000. The subscriber with one family member is eligible for service benefits where his income does not exceed \$2 500, and a subscriber with a family whose income does not exceed \$3 500

Medical care plan benefits can be retained by the subscriber in the event he changes his place of employment or is unemployed. Thus is a definite advantage Reciprocity privileges are also available in the event the subscriber changes his residence to an area served by another plan

The medical profession has met the need of the public to budget for medical care by providing a nonprofit plan in which the public may enroll on a voluntary basis have free choice of phy sician with no third party interference, and receive liberal benefits

#### SPECIALIZATION IN SURGERY

During the past decade there has been an in creasing tendency for specialization in all branches of medicine. Several explanations are apparent. Medical progress has been so rapid that it has become practically impossible for a single individual to keep up to date in all recent developments Per haps the possibility of lucrative financial return has influenced some to enter special fields and finally the public has learned to think in terms of specialists and to domand them when they seek medical care

The trend toward specialization has been par ticularly evident in the field of surgery. The American College of Surgeons and the Surgical Boards have maintained high standards and proscribed the minimum requirements of training for those who desire recognition as specialists There can be no question that the activities of the various specialty boards have raised the standards of patient care.

It should be emphasized, however that the specialty boards have made it clear that they are exam lning boards. The diplomates of the boards are not to be regarded as members of a union or a guild

who may do surgery to the exclusion of others.

It is safe to state that personal integrity cannot be evaluated accurately by any board. The variety be evaluated accurately by any board of cases and types of operations the surgeon under takes are his personal problem. The size and location of each community will influence the activi tles of individual practices.

Few surgeons have the opportunities of self improvement which will make it possible for them to excel in all fields of surgery. Moreover the public has demanded selective activity and sometimes the surgeon is labeled a golter specialist, a rectal specialist, a stomach specialist, or some other kind of specialist not by choice but because his work

is outstanding A broad general surgical back ground is essential to all surgeons

In generations past it was easy to find a surgeon who, on the same day would remove hemorrhoids tonsils, gallbladder and thyroid perform a colon operation operate upon a stomach and perhaps remove a uterus for good measure Such diver sified activities are now rarely necessary or advis-

The modern surgeon is not a manual laborer whose task ends and begins with the operation itself Surgical diagnosis and strict attention to preoporative preparation and postoperative care have become equally important to technical ability Buttonhole incisions and slap-dash, speedy operating have been replaced by careful dissections with the emphasis on the gentle handling of tissues and not

get in and out fast. Familiarity with physiology bacteriology, path ology and biochemistry influences not only the preoperative and postoperative program but the con duct of the anatomic dissection Perhaps the science of surgery is approaching the art of surgery

Few mourn the passing of the universal specialist but perhaps he is more desirable than the surgeon whose hands can only obey his brain in an area circumscribed by a mental-anatomic boundary Who then shall perform this or that operation? Where should the line of specialization be drawn?

Those who accept the grave responsibility of the care of the sick and injured should ask themselves is there available for this problem a surgeon better qualified than I? Reference and acceptance of a patient under these circumstances will bring to the public the real benefits of specialization and none of its handicape.—Brian Blades M. D. Medical Annals of the District of Columbia June 1947

CONTRIBUTION OF \$25 000 00 FOR RESEARCH ON MULTIPLE SCLEROSIS INITIAL GOAL OF \$100 000 00 MET

A contribution of \$25 000 made by Mrs. Percy S

Straus was announced in July by the Association for Advancement of Research on Multiple Sciences The organization further stated that with this

contribution an initial goal of \$100 000 for research on multiple sclerosis has been met

Mr Ralph I Straus a recent addition to the Board of Directors of AARMS, in presenting the contribution on behalf of his mother stated that although he had been familiar with the disease because of its appearance in a member of his family only recently had he become aware that it is one of the most prevalent of ne



# THE FAMILY DOCTOR

By NORMAN ROCKWELL

(Reprinted through the Courtesy of The Saturday Evening Post, Copyright, 1947, The Curtis Publishing Company)

The above painting appeared in color in a recent issue of the Saturday Evening Post—Its painter, Mr Norman Rockwell, is well known as a portrayer of realistic American life—Thus, he has included in his Americana the one man who since its beginning has been an integral part of that American life. The Journal feels that Mr Rockwell has done medicine a great honor in portraying so accurately the true service a family doctor gives to his patients, and we are happy to be able to reproduce his painting

The real service of the family doctor which is vividly shown in the painting is that the doctor is the family's friend. The family clearly shows its confidence in their doctor, and the doctor clearly shows his interest in his patients. That interest is an outgrowth of more than mere medical and scientific fact, it is an outgrowth of intimate knowledge of their mental as well as their physical ills. He knows that Jane, who has a weak heart, is over anxious about the baby because she was premature, and that for the good of both of them he must allay her fears, he knows that Bill, Sr., is a hard-working man, but with a small income because he had to leave school during the depression and never had the education he wanted, he sees that Bill, Jr., is alarmingly listless, but knows that Bill's team lost the football championship. All this knowledge means he can treat this family for their physical ills more intelligently, and, equally as important, that he can help them mentally

We know that America is proud of the tradition of the family doctor, and from its pride we feel that the American people will continue to defend this vital part of their lives For to lose it would mean that they would lose their lifelong friend—the family doctor

WLS

#### FORTY-FIRST ANNUAL MEETINGS

#### of the

#### DISTRICT BRANCHES

of the

#### MEDICAL SOCIETY OF THE STATE OF NEW YORK

#### PROGRAMS

#### Seventh District Branch

Thursday, September 25, 1947 Veterana Facility Bath, New York

-
Morning Session
10 00 a.m.— 'Primary Care of the Injured Hand
John C Detro M D , Rochester, plastic surgeon
Rochester General Hospital
"The Peptic Ulcer Problem
Ubert F R. Andresen, M.D. Brooklyn, profes-
sor of clinical medicine Long Island College of
Medicino
12 30 r m.—Luncheon
Introduction of Officers of the Medical
Society of the State of New York
Address by the President Louis H
Bauer M D , Hempstead
Business Meeting—Election of Officers
Afternoon Session
2 00 P M — Hypertension

Jacob D Goldstein, M D , Rochester, assistant professor of medicine and bacteriology, University of Roch ester School of Medicine and Dentistry "Office Management of Gynecologic

Complaints' Clyde L. Randell M D Buffalo professor of gynecology Univer-sity of Buffalo School of Medicine

Auxiliary to the Steuben County Medic	al Society
Officers-Seventh District Bra	ınch

Ladies will be entertained by the Woman's

President	Lloyd F Allen, M D Pittsford
First Vice-President	Kenneth T Rowe M.D Hornell
Second Vice-President	George H Gage M D Rochester
Secretary	James I Yanick, M D Hornell
Treasurer	Glenn C Hatch M.D Penn Yan

#### Presidents of Component County Societies

Monroe Ontario Senoca Steuben Wayno Lates
--

Robert J Thomas, M.D. Auburn
Melville A Hare M D Caledonia
Charles S Lakeman, M D, Rochester
William C Elkner M D, Culton Springs
David L. Koch M.D. Seneca Falla
Luther A. Thomas M D, Painted Poet
Charles L. Steyaart M D, Lyons
E. Carlton Foeter M D, Penn Yan

# Fifth District Branch

#### Tuesday September 30 1947 Hotel Utica Utica

## Afternoon Session

8 00 р.м --Symposium on Cancer Fred W Stewart, M.D pathologist, Memorial Hospital New York and associates (to be announced) Moderator Richard H Lyons M.D professor of medicine Syracuse University College of Medicine Business Meeting—Election of Officers

6 30 P.M -Dinner Introduction of Officers of the Medical

Society of the State of New York Address by the President Louis II
Bauer M D, Hompstead
"The Future of Public Health in New

York State Horman E Hilleboo M D State Commissioner of Health

Ladies will join the members of the District Branch for dinner

The Executive Committee of the Fifth District Branch will donate a prise of \$25 to that Woman s

County Auxiliary from which county there is the largest percentage of physicians registered at this meeting

#### Officers-Fifth District Branch

H Dan Vickers M D Prosident Little Falls James E. McAskill M D First Vice-President Watertown

Second Vice-President O D Chapman M D Secretary Symouse

#### Tressurer

#### Presidents of Component County Societies

Joseph W Conrad M.D Little Palls Herkimor Wendell D Georgo M.D Watertown Louis A Ayallone M D Lowvillo Richard B Cuthbert, M D Canastota Frederick T Owens M.D Utlea Jeffernon Lewis Madison Oncida Onondagu Arthur N Curtiss M.D Syracuse
Oswego Francis L Carroll M.D Oswego
St. Lawrence Donald C Tulloch M D Ogdensburg

New York Post-Graduate Medical

# Sixth District Branch

# Wednesday, October 15, 1947 High School Auditorium, West Main Street, Norwich

#### School and Hospital, assistant 2 30 P M —Registration chief, Allergy Chinic, Roosevelt 3 00 PM —"Recent Clinical Experience with Fura-Hospital William B Sherman, M.D., New York City, assistant attending, Roosevelt Hospital Louis Eugene Daily, M D, director of medical research, Eaton Laboratories, Norwich 4 00 P M -- "Poly cythemic Anemia" Officers-Sixth District Branch Samuel E Cohen, M D, pathologist, Ivan N Peterson, MD, President Arnot-Ogden Memorial Hospital, Owego Elmira Discussion by Victor W Bergstrom, M D, Binghamton, Ronald L Charles L Pope, MD, First Vice-President Binghamton Hamilton, M.D., Binghamton 5 00 P. u.—Business Meeting—Election of Officers Second Vice-President Norman C Lyster, MD, Norwich Elton R Dickson, MD. 6 00 r m — Dinner to be served at the Elks' Club, East Main Street, courtesy of the Secretary Binghamton William A Moulton, M D, Eaton Laboratories Treasurer Candor Introduction of Officers of the Medical Society of the State of New York Address by the President, Louis H Bauer, M D, Hempstead

Broome

Chemung Chenango

Cortland Delaware Otsego

Schuyler

Tioga Tompkins

## Evening Session

Afternoon Session

7 30 P v — Symposium on Asthma Its Diagnosis and Therapy—Conducted by Robert Chobot, M.D., New York City, assistant clinical professor of pediatries, College of Physicians and Surgeons, Columbia University chief of pediatric allergy,

# Presidents of Component County Societies

Jacob C Zillhardt, M D, Binghamton Donald J Tillou, M D, Elmira John A Hollis, M D, Norwich Fred A Jordan, M D, Cortland
Elliot Danforth, M D, Sidney
Charles B Kieler, M D, Cooperstown
Francis C Ward, M D, Odessa
Harry S Fish, M D, Waverly
Henry W Ferris M D, Ithaca

# PROSTHESES, 1876

In consideration of the plight of amputees of World War II and their difficulties with artificial limbs, it is interesting to read the catalogues of various artificial leg manufacturers of the period following the Civil War

The following is composed of excerpts from a catalogue called Mark's "Patent Artificial Limbs with India Rubber Hands and Feet," published in New York in 1876 It quotes from an article in Appleton's Journal, June 19, 1875 "Such improvements have been made in late

years that, in all but a sense of touch, an artificial leg performs the most important duties of a natural one, allowing the wearer to walk, run, or sit at ease, and to endure an astonishing degree of fatigue in an upright position — It is noiseless, and only an expert can detect it "

n detect it "
"A brevet major of United States Volunteers,
"A brevet major of United States Volunteers, "I who was cut in two during the war, writes, 'I walk six miles every day without a cane or other assistance' Another martyr of gunpowder declares, 'I am employed in a locomotive works, and with the aid of an artificial leg I am able to support a large family. Think of supporting a large family on an artificial leg, and dandling a baby on an artificial knee! And what a sermon and example it is to those who complain that they cannot afford to marry with even the two natural limbs at their service<sup>†</sup>

"Still another writes, 'With my artificial leg I have visited the Highlands and all the noteworthy scenery of Ireland, Wales, England, Germany, France, and Switzerland

"We imagine that the wearers of these artificial limbs grow attached to them as to a meerschaum pipe, and it occurs to us that there must be a large amount of satisfaction in taking one's leg off and rubbing it up and down in a fondling way Some connoissours have collections of legs—week-day legs, Sunday legs, dancing legs, and riding legs, each expressly made for a distinct purpose But this is vanity and leadeth only unto vexation of the

(Marks, according to his catalogue, was "commissioned by the Surgeon-General to furnish artificial limbs to Commissioned Officers, Soldiers and Seamen of the United States Army and Navy, free of charge to them, agreeable with all Acts of Congress relating thereto")—Army Medical Library News, July, 1947

## House of Delegates

# Minutes of the Annual Meeting

May 5 to 7, 1947

[Continued from page 1920 September 1 saue]

[Sections 52-68 appear in this issue For subject index see August 15 issue page 1789]

# Morning Session

Tuesday May 6 1947

The session convened at 9 10 A.M

SPEAKER ANDRESEN The House will please come to order

Several Chairmen of Reference Committees have informed me that the members of their committees have not signed their reports. Will any members here who have not signed the report of their Reference Committees please stop outside and just go across the hall and sign those reports? It will only take a minute

I want to announce that the banquet will be held on Wednesday night Thoy are very antious to sell some tickets for that banquet They have not been selling very well, so please buy yours as soon as possible

Section 52 (See 19)

Introduction of Representatives of Other State Societies

SPEAKER ANDRESEN Vesterday we introduced delegates from other state societies and one was absent. He is an old friend of ours He ran our scientific programs for several years, and has done a great deal of work for our Society. However he has now abandoned New York and has gone to Vermont from which State Society he has been sent here as a delegate I will ask Dr. McKenna if he will escort to the platform Dr. D. Dexter Davis the delegate from Vermont.

There was applause as Dr Donald E McKenna escorted Dr D Dexter Davis to the plat form

DR. D DEXTIR DAVIS Mr Speaker and Members of the House of Delegates I am sorry that I am a little late in showing up to represent the State of Vermont, but I know you gentlemen will understand when I say that we just finished sugaring and that fishing opened the day before yesterday

I feel in coming back here like the old Vermont farmer who was met on the road just below my place It is a country road, and we have an expression up there that Vermont is where you find it. Well, this big automobile drove up to him and stopped, and the man driving the car looked out and said Can I get into Brattleboro if I continue right straight ahead on this road?

I don t know

If I go back to that fork that I just passed and take the other road can I get into Brattleboro? I don't know

By this time the city fellow was gotting quite mad so he said. For a fellow that lives up here you don't seem to know much about the place

The farmer said No but I ain t lost (Laughter)

So gentlemen, that is the way I feel in coming back to you It seems like being at home again

I bring you the greetings of the State of Vermont and was also authorized to tell you that if you want to forget the problems connected with medicine any time, just come up there and if you will contact any member of the Vermont State Medical Society we can show you where you can get plenty of fish and lots of maple syrup (Applause)

Section 58

Expression of Appreciation by Retiring Commissioner of Health

Speaker Andresen Our President Dr Bauer has an announcement to make.

PRESIDENT BAULE Mr Speaker I have a letter which I received from the Commissioner of Health and in which I thought the House would be inter cated. It is dated April 25 1947

Dear Doctor Bauer

On the eve of my retirement as State Commissioner of Health, I want to express to the Council my deep appreciation for the cordial support given by it to so much of the work of the Department during my incumbency. I am particularly

grateful to the Council Committee on Public Health and Education, the members of its several subcommittees, and to the officers of the Association who have so frequently given their time to meetings with representatives of the Department

The readiness of these busy practitioners to give freely of their informed advice on many different subjects affecting Department policies and medical practice is worthy of more generous reward than any words from me Yet since that reward than any words from me Yet since that is all I can give, I think you should know the high estimate I place upon the value of these meetings

I feel that I should especially mention Dr O W H Mitchell, under whose chairmanship the Committee has functioned during most of my commissionership His broad understanding, his wise guidance, and (shall I say?) ineffable diplomacy, have made for the free discussion of problems without the heat that so often provokes misunderstanding and needless dissension Due largely to his leadership, I think that there is a realization by the medical profession that the vast majority of modern fulltime health officers are well-educated physicians with special knowledge in their field, and an appreciation by public health officers that the vast majority of practitioners are sincere, solid citizens equipped for their profession and anxious for the betterment of mankind

Sincerely yours, /S/ Edward S Godfrey, Jr , Commissioner of Health

I thought that should be spread on our minutes

I have replied to it, and told him I agreed with everything he said about Dr Mitchell, but that I felt he was due a little praise himself for the way that he had cooperated, and his whole Department had, with the Society while he was Commissioner (Applause) Speaker Andresen

I am going to call now for any further resolutions We wish to get them in as soon as possible so we can refer them to reference committées

Section 54

Amendment to Bylaws Relating to Active Membership

DR EZRA A WOLFF, Queens I am instructed to introduce this amendment to the Bylaws which relates to Active Membership

It is proposed to amend the Bylaws, Section 1,

first sentence, to read

"The active members shall be Doctors of Medicine who are active members in good standing of the component county medical societies?

SPEAKER ANDRESEN That being an amendment to the Bylaws it has to be published, and it can then be voted on next year

Section 55 (See 106)

Medical Indemnity Plan-Genesee Valley Medical Care, Inc.

DR LEO F SIMPSON, Monroe This is a resolution introduced at the request of the Monroe County Medical Society

"The Medical Society of the County of Monroe requests the House of Delegates to endorse the Genesee Valley Medical Care, Inc., Rochester, New York "

Speaker Andresen Referred to the Reference Committee on Report of the Council, Part VII, Medical Care Insurance

(See 107) Section 56

Medical Indemnity Plan-Central New York Medical Plan, Inc

DR LEO E GIBSON, Onondaga This resolution 18 offered by the County of Onondaga Medical Society, and concerns a Medical Indemnity Plan

"The Medical Society of the County of Onondaga requests the House of Delegates to endorse the Central New York Medical Plan, Inc., Syra-cuse, New York."

Speaker Andresen Referred also to the Reference Committee on Report of the Council, Part VII. Medical Care Insurance

Are there any further resolutions?

There was no response

If there are, no further SPEAKER ANDRESEN resolutions to be introduced at this time, we will go on and hear some reports of Reference Committees Is there any reference committee ready to report?

Section 57 (Sec 10)

Report of Reference Committee on Report of Coun-Maternal and Child Welfare cıl-Part II

DR S B BURK, New York I think you can all relax for there is nothing controversial about this

Your Reference Committee carefully studied in detail Part II of the Report of the Council relating to Maternal and Child Welfare and observed that there were meetings of the Council Committee on Public Health and Education and the Subcommittees on Maternal Health and Child Welfare at the request of the Director of the EMIC Bureau of the New York State Department of Health, New York City, on June 12 and August 14, 1946, to consider the qualifications of physicians who requested specialist ratings in the EMIC program I move the adoption of this part of the report

The motion was seconded, and as there was

no discussion, it was put to a vote and was unani-

mously carried

The Reference Committee com-Burk mends highly the choice of physicians of the Medical Society of the State of New York following the communication on August 19, 1946, to act as advisers to the EMIC Bureau of the New York State Department of Health, in processing the applications from physicians requesting special rating in the EMIC program This was approved at the meeting of the Council in September, 1946 The Reference Committee takes notice of the wisdom of the statewide composition of this important advisory committee, who will act also in the Rehabilitation Program and any other activity for which the Department of Health desires such special service move the adoption of this part of the report

The motion was seconded, and as there was no discussion, it was put to a vote and was unani-

mously carried Dr Burk

DR BURK The usefulness of the Subcommittees on Maternal Health and Child Welfare was again emphasized by having the Chairman of each Committee present with members of the Subcommittee on Rehabilitation and also physicians of the Medical Society of the State of New York designated as advisers to the State Department of Health, plus officers of the Medical Society of the State of New York and representatives of the New York State York, and representatives of the New York State Department of Health at a meeting on September 11, 1946, to consider the qualifications of the physicians who requested specialists' rating We recommend an expression of appreciation for such untiring efforts when it is recorded that parts of the Com-mittees on Maternal Health and Child Welfare were also in session on the previous day I move the adoption of this part of the report

The motion was seconded, and as there was no discussion it was put to a vote and was upani

mously carried

Dr. Burk With continued and unceasing inter est, the Subcommittee on Maternal Welfare met with the Committee on Public Health and Educa tion in New York on November 12, 1946 to discuss the postgraduate education program with regard to holding regional maternal welfare days throughout the State At this meeting it was recommended that letters be sent to Regional Chairmen in Obstet rics (which was done) expressing the desire of the Committee that such meetings be held Such proressive activities call for special thanks of the House of Delegates and the Reference Committee makes this recommendation I move the adoption of this part of the report.

The motion was seconded, and as there was no discussion, it was put to a vote and was unani

mously carried

Dr Burk It also comes to the attention of the Reference Committee that the Chairman of the Subcommittee on Maternal Welfare attended meetings

of the Subcommittee on Rehabilitation

The Membership of the Subcommittee on Mater nal Welfare and the high calibre of Regional Chair men in Obstetrics also appears in the report Reference Committee has taken due notice thereof and wishes to express itself accordingly I move the adoption of this part of the report

The motion was seconded, and as there was no discussion, it was put to a vote and was unani-

mounly carried

Dr. Burk The Reference Committee recommends the approval of the further activities of the Subcommittee on Maternal Welfare when it met with the Council Committee on Public Health and Education at the request of the New York State Department of Health on April 9, 1947 to ductuss the development of a colored film library to be available in postgraduate instruction I move the adoption of this part of the report.

The motion was seconded and as there was no discussion it was put to a vote and was unani

mounly carried

Dr. Burk I now move the adoption of the report in its entirety relating to Maternal Welfare

The motion was seconded and as there was no discussion, it was put to a vote and was unanimously carried

Dr. Burk Concerning Child Welfare laudatory comment is made by your Reference Committee in connection with the various meetings of the Sub-committee on Child Welfare with the Committee on Public Health and Education which considered the qualification of physicians requesting specialists ratings in the E.M.I.C. Program. I move the adoption of this part of the report.

The motion was seconded, and as there was no discussion, it was put to a vote and was unanimously

carried

Dr. Burk The Chairman of the Subcommittee on Child Welfare at meetings of the Council Com mittee on Public Health and Education with the Subcommittee on Rohabilitation is a further expresmon of intensive activity which your Reference Committee recognises and wishes that this recognition be expressed to the House of Delegates I move that this part of the report be adopted

The motion was seconded and as there was no discussion, it was put to a vote and was unanimously

carried

While the general practitioner is not Dr. Burk often given the amount of recognition due the Subcommittee on Child Velfare held meetings on December 4 1946 and January 8 1947, to further consider the plan of the New York State Depart consider the plan of the New York State Depart ment for the establishment of 'Pediatric Institutes for General Practitioners The problem has not been sufficiently developed to receive the approval of the Committee on Child Welfare This praiseworthy project is to have the State divided into regions, with the Institute centered around the medical schools in the State The Reference Committee recommends a continuation of this study and requests the endorsement of the House of Delegates I move the adoption of this part of the report.

The motion was seconded, and as there was no discussion, the motion was put to a vote and was

unanimously carried

On January 8, 1947 the Subcom Dr. Burk mittee on Child Welfare discussed the use of the BCG Vaccine in New York State as part of the Tuberculosis Control Program The above Com mittee is of the opinion that an educational program be inaugurated to inform the medical profession of this State about BCG immunization. This im portant and very desirable project is recommended for your approval. I move the adoption of this part of the report
The motion was seconded, and as there was no

discussion it was put to a vote and was unanimously

Dr. Burk The importance of child welfare has been considered by your Subcommittee on Child The Reference Committee observes the outstanding ability of the Regional Chairman in Pediatrics (for regions comprising counties as shown in the list of Regional Chairmen of Obstetrics) which applies in this report. I move the adoption of this part of the report.

The motion was seconded and as there was no discussion it was put to a vote and was unanimously

carried

Dr. Burk I move the adoption of the report as it pertains to child welfare

The motion was seconded, and as there was no discussion it was put to a vote and was unanimously carried Dr. Burk I have just one more comment.

want to move the adoption of the Report of the Council Part II relating to Maternal and Child Welfare, which makes the matter all-inclusive.

The motion was seconded, and as there was no discussion it was put to a vote and was unanimously

carried Speaker Andresen Thank you very much Dr Burki

(See 11) Section 58

Report of Reference Committee on Report of the Council—Part IV Public Health and Education

DR. ABRAHAM KOPLOWITZ Kings I am afraid I will not have very many motions to make in the course of this report so I will just make the entire

report, as it can be considered as a whole.

This portion of the report of the Committee of Public Health and Education deals with the Subcommittees on Cancer Hard of Hearing and the Deaf Montal Hygione County Health Depart ments, Homologous Serum Jaundice, and BCG Immunization

The Subcommittee on Cancer, under the chairmanship of Ralph T Todd, met several times with the Public Health Committee, and some officers of the Society, and representatives of the State Department of Health for the purpose of integrating the work of several agencies, such as the State Division of the American Cancer Society and the State Department of Health Their resolution was adopted by the Council of the State Society

In February of this year plans were formulated for regular meetings of the State Department of Health, the Chairman of this committee, and the Chairman of the Subcommittee on Cancer A number of lectures and teaching days have been given in various

parts of the state

The Subcommittee on Hard of Hearing and the Deaf, under Dr G D Hoople, met with the Committee on Public Health and Education and representatives of the Departments of Health, Education and Welfare, and planned for the education and maintenance of hearing centers in strategic cities of In the near future all the main cities in the state

the state will have such centers

The State Society has received a communication from Dr W W Bauer of the American Medical Association relative to a resolution that was passed regarding the statewide mental hygiene program, and the Council of the State Society authorized a committee to study the matter This subcommittee is considering matters pertaining to the outpatient treatment of veterans with psychiatric disabilities, and has communicated with the Joint Legislative Committee of the state as to the need of research and treatment of cerebral palsy

The State Department of Health has requested the Committee on Public Health and Education to discuss the extension of the Public Health Program in the State, with particular emphasis on the health departments Dr Mitchell felt that this should be discussed by the Planning Committee of the State

At the request of the Assistant Commissioner of the State Health Department for Medical Administration, the Public Health Committee studied and approved a plan for the Department of Health to prepare a report form and a study of the incidence of homologous serum naundice in patients who have been transfused with dried blood plasma which the Department is distributing throughout the State The report form is to be approved by the Committee on Public Health and Education and will be sent to attending physicians for information about hepatitis and jaundice in anyone who has received injections of their plasma products. Such a form has been approved

The Committee on Public Health and Education, with the Committee on Child Welfare and representatives of the New York State Department of Health, met with the representatives of the nine medical schools of New York State, and after a thorough discussion recommended that an advisory committee be appointed by the New York State Department of Health and the State Medical Society to work out a plan whereby instruction would be available for those who are to be in charge of BCG immunization and for county medical societies, hospital staffs, and other medical groups This recommendation was approved by the Council of the Society

Your Reference Committee believes that the Council Committee on Public Health and Education

and its various subcommittees have done an excel lent 10b in these departments

I move the adoption of the report as a whole

The motion was seconded, and as there was no discussion, it was put to a vote and was unanimously carried

Section 59

Report of the Reference Committee on Report of Council—Part VIII Veterans Affairs and Liaison with US Veterans Administration

DR LEO E GIBSON, Onondaga The work of the Council Committee on Veterans Affairs has been noted with commendation

The recommendation of the committee that it be disbanded and further inquiries answered by the

Secretary is approved

The work of the Council Committee on Liaison with the Veterans Administration has been noted There were no recommenda-The Reference Committee with commendation tions in the report recommends the continuation of this Committee

I move the adoption of the report

The motion was seconded, and as there was no discussion, it was put to a vote and was unanimously carried

Section 60 (See 29)

Report of Reference Committee on Report of Council—Part VIII Equal Privileges for Returning Veterans (Treatment of Veterans)

DR LEO E GIBSON, Onondaga On the resolution introduced by Dr William Ostrow, of Kings, on the subject "Equal Privileges for Returning Veterans," and reading

"WHEREAS, a number of physicians, citizens of the United States, graduates from foreign medical schools, the majority of whom are members of the Medical Society of the State of New York, honorably served as commissioned officers in the armed forces, and

"WHEREAS, these veterans were licensed to practice medicine in the State of New York, and "WHEREAS, these veterans now find that the

Veterans Administration of the United States is not according them the same privileges to treat veterans as are accorded to the graduates of

American schools, be it "Resolved, that the House of Delegates go on record as favoring and urging the Veterans Administration to give these medical veterans the same status as is given to the veterans who graduated from American schools, and be it further "Resolved, that a copy of this resolution be

printed in the State Medical Journal and copies of this resolution be forwarded to the Coordinator of the Veterans Bureau in New York"

This resolution is disapproved as not being in agreement with facts presented to the Reference Committee by Dr Frederick E Lane, Director of the Outpatient Department of the Veterans Administra-tion in New York State I move the adoption of the recommendation of the Reference Committee

DR JOSEPH P HENRY, Monroe I second the

motion

SPEAKER ANDRESEN You have before you the recommendation of the Reference Committee, which carries with it the disapproval of the resolu-Is there any discussion on the motion which is to adopt the recommendation of the Reference Committee?

DR ALFRED M HELLMAN, New York Would Dr Gibson please tell us in what way Dr Lane says this is not in accordance with the facts. From everything we have read in the state journals and other periodicals, that would not seem to be so would like to hear why Dr Lane says it is not in accordance with the facts

Dr. Gibson Dr Lane is here, and he can an-

swer that, if you so desire DR. HELLMAN We should have that information before we vote on this motion

Yes. Dr. Gibson If there is no objection on Speaker Andresen the part of the House, we could ask Dr Lane to present that. Is there any objection? Hearing none, we will ask Dr Lane to present that information to

us (Applause)
DR. FREDERICK E. LANZ The Veterans Administration under the Medical Care Plan does not have any differentiation between men who are heensed to practice in the State of New York. Their school of graduation is of no concern to us under the Medical Care Plan The only requirement is beense in the State of New York. That is

Statement No 1 Statement No. 2 is that the Professional Standards Board, of which I was the Chairman for the State of New York, did not have the power to approve for full-time or part-time employment by Veterans Administration graduates of schools other than Grade "A" Schools. Those applications had to be forwarded to Washington to our central office. Just as the graduate of our Grade "B Schools, let us say Middlesex, must have his application forwarded to Washington for action so graduates of foreign schools require the forwarding of their applications to Washington There was no differentiation as far as we were concerned between the schools, but it was necessary to send these papers to Washington first to have the approval of the schools We, in New York, have no record of the qualities and standards of the schools of the European universities.

Dr. ABRAHAM KOPLOWITZ Kings Your second statement does not seem to agree with the first. What do they do in Washington about this?

DR. LANE We have many men in our employ

We have many men in our employed who are graduates of foreign schools, which I think answers the question very pertinently SPEAKEN ANDRESHY Is there any further discussion? If not, thank you very much Dr Lane The question was called and the motion was

put to a vote and was carried to accept the recom mendation of the Reference Committee

Section 61 (See 34)

Report of Reference Committee on Report of Councll-Part VIII Veterans' Dues

Dr. Leo E. Gibson, Onondaga On the resolution introduced by Dr Exra A. Wolff of Queens, reading

WHEREAS, the House of Delegates has adopted the principle of modifying payment of dues by members of the Medical Society of the State of New York in active military service for the dura

tion of such service, and Wheneas, so-called terminal leave is included in the term of active service therefore be it

Resolved that the period of modified dues pay ment be calculated from the end not the beginning, of the 'terminal leave.'

This resolution is approved by the Reference

I move the adoption of this portion of the report

DR NELSON W STROHM, Erra I second the motion

There being no discussion the motion was put to a vote and was unanimously carried

Section 62 (See SO)

Report of the Reference Committee on Report of Council—Part VIII: Equal Privileges for Returning Veterans (Postgraduate Training)

Dr. Leo E Gibson Onondaga Reporting on the resolution presented by Dr William Ostrow, of Kings on Equal Privileges for Returning Veterans, read

"WHEREAS, a number of physicians, citizens of the United States, graduates from foreign medical schools, the majority of whom are members of the Medical Society of the State of New York, honor ably served as commissioned officers in the armed forces and

"WHEREAS, these veterans were licensed to practice medicine in the State of New York and

"Whereas, these veterans now find that they are denied the same opportunities for postgraduate study and training in accredited medical col-leges and hospitals as the graduates of American colleges, be it 'Resolved, that the House of Delegates go on

record as favoring that these veterans be accorded the same privileges to obtain postgraduate train ing as the graduates of American schools, and be

it further

Resolved that a copy of this resolution be printed in the State Medical Journal and copies of this resolution be forwarded to the colleges and hospitals giving poetgraduate instruction in the State of New York

This resolution was approved by your Reference Committee I move the adoption of this report. DR. WILLIAM KLEIN, Bronz I second the mo-

There being no discussion, the motion was

put to a vote and was unanimously carried

Section 63 (See 37)

Report of Reference Committee on Report of Council-Part VIII Medical Consultants in the Veterans Administration

Dr. Lzo E. Gibson Onondaga On the resolu-tion presented by Dr Benjamin M Bernstein of Kings, concerning Medical Consultants in the Veterans Administration, and reading

WHEREAS, the Veterans Administration has initiated a policy of appointing part-time medical consultants to supplement their own staff and

WHEREAS, these consultants are selected by committees of deans from medical schools, and WHEREAS, it is the policy of these deans to

select no consultants except those who are on the teaching staffs of medical schools, and

Witnessas, this policy discriminates against other qualified and competent specialists outside of medical schools and establishes an exclusive monopoly of veteran consultant care and

Whereas, this discriminatory practice of consultant selection deprives the veteran of some of the best medical skills, particularly by veteran physicians who held responsible positions during the war and best understand the problems of the

veteran therefore, be it

Resolved, that the Medical Society of the State
of New York go on record as being opposed to the present process of selection for consultant Veterans Administration medical specialists, and that the responsibility for consultant selection be placed in the hands of the Council Committee on Liaison with the Veterans Administration with the aid of the local county society and the present deans' committee"

This resolution is approved by your Reference Committee

I move the adoption of this portion of the report I second the DR NELSON W STROHM, Erre motion

SPEAKER ANDRESEN It has been regularly moved and seconded that the report of the Reference Committee, carrying with it the approval of the resolution, be adopted Is there any discussion?

SECRETARY ANDERTON May I move an amendment to the effect that the Secretary be instructed to send a copy of this resolution to each of the deans of the nine medical schools in New York State

DR JOHN L O'BRIEN, Bronx I second the

amendment

There being no discussion, the amendment was put to a vote and was unanimously carried

The amendment is carried SPEAKER ANDRESEN We now come to the original motion as amended Is there any discussion?

ASSISTANT SECRETARY FREY It would appear to me that in the whereases there is a good deal of If we are going to adopt this resolution I think we should amend the part that says that it is the practice of all deans to appoint only their own members of their staffs Do we know that? We might say, "It would appear to be so," or "in some

instances it has appeared to be so " Do you wish to make that SPEAKER ANDRESEN

amendment?

Assistant Secretary Frey Yes, I would offer that as an amendment

DR EUGENE H Coon, Nassau I second that

DR BENJAMIN M BERNSTEIN, Kings That is a Although I see no objection to the known fact amendment, it is a known fact that the consultants chosen by these deans consist of men on their own teaching staffs only

SPEAKER ANDRESEN Do you accept that as an

amendment?

DR BERNSTEIN Yes, I have no objection to the

amendment

Speaker Andresen It may not be true in all instances, and this states it as being apparently so instead of making the absolute statement

The question on the amended motion was called, and it was put to a vote and was unanimously carried

Dr. Gibson Now I move to adopt the report of the Reference Committee as a whole, as amended

The motion was seconded, and as there was no discussion, it was put to a vote and was unanimously carried

(There was an announcement by the Speaker concerning the banquet )

Section 64 (See 40)

Report of Reference Committee on Report of Council—Part VII Medical Indemnity Plan (Northeastern New York Medical Service, Inc.)

DR DENVER M VICKERS, Washington Your Reference Committee on Council Part VII, Medical Care Insurance reports as follows

In regard to the resolution introduced yesterday by the County of Albany your Reference Committee moves that the Northeastern New York Medical

Service, Inc be approved

The motion was seconded, and as there was no discussion, it was put to a vote and was unanimously

DR SAMUEL Z FREEDMAN, New York you give us in a few words generally what this company is to do? Does it correspond to the United Medical Service that we have in New York County?

Yes

DR VICKERS
DR FREEDMAN It is the same
DR VICKERS Yes
The Properties That is what I thought, but I wanted to make sure

Section 65 (See 13)

Report of Reference Committee on Report of Councıl—Part VII Medical Care Insurance

DR DENVER M VICKERS, Washington Your reference committee is pleased with the work of the Subcommittee of the Council on Medical Expense Insurance during the past year as one of the principal methods of combating the advance of state medicine It is hoped that the active work of the committee and of Mr George P Farrell, Director of the Bureau of Medical Care Insurance, can be extended during the years ahead

We approve the suggestion of the committee for continued study leading to a uniform contract on a

statewide basis

We approve of the recommendation of the committee in regard to standards of acceptance for approval of nonprofit voluntary medical care plans in New York State, which are as follows

Local Approval

Approval of the county medical societies in whose area it operates

In the event a county society does not approve a plan, a special committee of three members is to be appointed one by the plan, one by the county medical society, and one by the Medical Society of the State of New York, to investigate and study the reasons why approval was withheld

If it is the opinion of a majority of the committee, approval will be granted to the plan

after consideration

Professional Control

The Board of Trustees shall contain a majority of physicians

That these representatives shall be members of the Medical Society of the State of New

The medical profession is to assume responsibility for the medical services included in the benefits

Free Choice of Physician

There shall be no regulation which restricts the choice of a qualified doctor of medicine in the locality covered by the plan, who is willing to participate and render service under the conditions established

When care has been rendered by a nonparticipating physician and claim filed for such care, payment shall be made direct to the nonparticipating physician or to the subscriber upon

presentation of a receipted bill

Underwriting Subscriber premium rates should be adequate to provide for the benefits offered and the risks involved in the contract

[Continued on page 2022]



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## [Continued from page 2020]

2 Plan should be organized and operated to provide the greatest possible benefits in medical

care to the subscriber

All plans shall conform with state statutes as set up under the New York State Insurance Department with due consideration for earned premiums, administrative costs, and reserves for contingencies

Enrollment

Enrollment procedures shall be on a sound basis so as not to expose the plan to adverse

It is recommended that enrollment be offered to individuals at the earliest possible date that experience of the plan warrants

Descriptive folders and all promotional material wall state clearly and accurately the benefits offered by a plan, and also in the same manner, exclusions in the contract

Reports

All plans which have received approval, or are seeking the approval of the Medical Society of the State of New York, shall submit quarterly reports on forms provided for that purpose, to the Bureau of Medical Care Insurance of the Medical Society of the State of New York

SPEAKER ANDRESEN

Duration of Approval Approval by Medical Society of the State of New York shall be for a period of one year, at the end of which, review of all plans will be made by an appropriate committee of the Medical Society of the State of New York, to determine eligibility for renewal of approval

We move approval of this portion of the report DR A WILBUR DURYEE, New Yorl I second

It has been regularly

the motion

moved and seconded that this portion of the report Is there any discussion?

DR ABRAHAM KOPLOWITZ, Kings In the early part of the conditions of the Plan, where they specify that the majority of the Board of Trustees shall be physicians and members of the Medical Society of the State of New York, I would like to amend that to read instead of Board of Trustees "the governing body" Some might call it a Board of Directors and Some might call it a Board of Directors and at the same time have a Board of Trustees of which the majority of members may be doctors, while the controlling board may be more representative of lay people than of doctors and not be called the Board of Trustees Instead of "Board of Trustees" the term should be "Governing Body," whatever they happen to call it

DR SAMUEL Z FREEDMAN, New York I second

that amendment

Dr. Thomas M D'Angelo, Queens I am going to discuss this amendment I don't think it goes far enough by only having on the governing body a majority who are doctors and members of the State Society Those physicians should be recommended by the Medical Society of the State of New York That is a very, very important precaution because we can have representatives on that governing body who are members of the Medical Society of the State of New York yet who have not the viewpoint of organized medicine. Therefore, I feel that the majority of physicians on such governing body should be recommended by our State Society

DR HOMER J KNICKERBOCKER, Onlario

ond that amendment

DR HARRY ARANOW (Councillor) Point of in-

formation, Mr Chairman What I would like to know is, has this Reference Committee been empowered to set up rules and regulations for the organization of these insurance plans? This is a county matter, and ought to be studied carefully and worked out by men who are experienced in insur-I have no objection to this particular amendment, but it seems to me that the Reference Committee has nothing to do with setting up rules that will establish medical care insurance plans for the whole State of New York and that the counties must follow in organizing them

SPEAKER ANDRESEN The Reference Committee is simply discussing the suggestions that were made

by the Council
DR VICKERS That is right

And is recommending that SPEAKER ANDRESEN they be now adopted by this House

Dr. Aranow Is that on the report of the Coun-

SPEAKER ANDRESEN Yes, this is the Reference Committee on the Report of the Council, Part VII, Medical Care Insurance, that is reporting

DR VICKERS It provides that the plan must have the approval of the county medical societies in

whose area it operates

DR ARANOW I just wanted to make sure that was included I had overlooked that in the reading DR VICKERS It is in the first section headed "Local Approval"

DR KOPLOWITZ I will accept Dr D'Angelo's amendment to the amendment as part of the original amendment and save the necessity for taking an additional vote

SPEAKER ANDRESEN The amendment then is that a majority of the governing body shall be physicians who are members of the Medical Society of the State of New York and selected or approved

Dr. D'Angelo Recommended

Recommended by the SPEAKER ANDRESEN Medical Society of the State of New York.

The question on the amendment was called, and it was put to a vote and was unanimously carried, then the question on the motion as amended was called, and it was put to a vote and was unanimously carned

DR VICKERS I move the adoption of the report

as a whole, as amended

The motion was seconded, and as there was no discussion, it was put to a vote and was unanimously carned

DR BENJAMIN M BERNSTEIN, Kings the State Society shall do the recommending? Who

is empowered to recommend and O K, these men?

SPEAKER ANDRESEN The motion has been carried, so I guess the State Society will have to work that out in some way

Section 66 (See 16)

Report of Reference Committee on Report of Council—Part XII Miscellaneous

Dr. Joseph A. Geis, Essex After careful study, we appreciate the amount of work done by the Coordinating Council on Nursing Problems We believe that your House of Delegates should urge the Coordinating Council to carry out the following recommendations

Explore the possibility of making Regents Scholarships available to nurses in training

Urge community and industrial groups to provide scholarships for nurses in training

[Continued on page 2024]

Candy and the

Cephalic Phase of Digestion

That the pleasant sense of satiety and satisfaction which follows a good meal is conducive to trouble free di gestion has been repeatedly experienced by everyone. The psychic influence of the sight and taste of attractive food upon the secretion of



the digestive juices and upon gastrointestinal motility is probably the basis for this observation. A meal which ends with a piece or two of candy is usually regarded as a satisfying meal. In this manner candy can rob even an ordinary meal of its drabness. Children look forward to this treat at the end of their meals, this very anticipation encourages them to eat their other foods more eagerly. And few indeed are the adults who do not enjoy a sweet after lunch-or dinner.

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COUNCIL ON CANDY OF THE



[Continued from page 2022]

Work for inclusion of nurses in Social Security benefits

Set up Coordinating Councils on Nursing Problems on the county level

Approve the employment of practical nurses in hospitals

Physicians individually to use their influence for the recruitment of nurses

Practical nurse organizations to be given full membership status on the Coordinating Council

on Nursing Problems
Sponsoring bodies to be asked for suggestions of program of recruitment and education of nurses,

both professional and practical
Sponsoring bodies to endorse the Coordinating
Council on Nursing Problems and authorize con-

I move the adoption of this report

tinued representation

The motion was seconded, and as there was no discussion, it was put to a vote and was unanimously carried

DR GEIS The report of the Council Committee on Medical Licensure shows considerable work and study We agree with the Council Committee in making the following recommendations

"(1) That citizenship as a requirement be incorporated in the Medical Practice Act,

"(2) In lieu of this, that an amendment similar to Article V, Section 2193, of the California Medical Practice Act be introduced. This is in addition to other accepted requirements that we now have in our Medical Practice Act and would be added to alleviate some of the difficulties we have encountered with foreign licensure.

""If the applicant is not a citizen of the

"If the applicant is not a citizen of the United States, the country in which he has been licensed to practice medicine and surgery will admit to practice therein citizens of the United States upon proof of prior admission to practice medicine and surgery in some state of the United States, or upon proof of matters similar to those required in this section for graduates of foreign medical schools'

"(3) In relation to the number of repeat examinations, a necessary change in the law would have to be made in Section 1258 of the Statutory Law This insertion was approved by the Council

"If a candidate fails on the first examination he may have a second examination without fee '

This phrase is then to be inserted

"A candidate, who through failures of three examinations has shown insufficient knowledge for admission to the practice of medicine, should be excluded from further examination by the Department until he presents evidence of further study in a regular school of medicine satisfactory to the Department'

"(4) As regards the special privileges for candidates from unapproved schools, these should be rescinded as soon as clearance has been made of all worthy applicants"

I move the adoption of this portion of the report Dr. Donald D Prentice, Albany I second the motion.

Speaker Andresen It has been regularly moved and seconded that this portion of the report be adopted Is there any discussion?

DR ABRAHAM KOPLOWITZ, Kings That portion that deals with failing three times and then being required to take certain prescribed courses I think is going to work a hardship It is not so easy for these men to get training in schools They have to enroll A man may fail in one for a year or two, or more subject or two and be allowed to take those over again, as is the custom now I think changing that would be a little bit unfair A lot of these boys may be graduates of our own schools and citizens of our own state I think this part should be left alone and should be omitted

Speaker Andresen Do you want to make an

amendment to that effect?

DR KOPLOWITZ Yes, I make an amendment that that part relating to taking prescribed courses if they fail three times be omitted

DR AARON KOTTLER, Kings I second the

amendment

Speaker Andresen Is there any discussion of the amendment?

DR EZRA A WOLFF, Queens It would seem that that amendment negates the entire recommendation of the committee, and I think it would be wise for the House to consider that fact when it votes on the amendment

DR HARRY ARANOW (Councillor) May I respectfully suggest that instead of taking up the recommendations wholesale we take up each one separately, and vote on them one at a time? In that way we will know what is being passed, otherwise there may be a little confusion as a man may disagree with one item and agree with another

Speaker Andresen Have you some other one

you disagree with?

DR ARANOW It seems to me that we could discuss it more intelligently if each recommendation were put to a vote separately instead of in this wholesale fashion

DR ABRAHAM M RABINER, Kings That last item about graduates from unapproved schools, that they shall not be determined until they have clearance, that is rather a vague statement What kind of clearance is intended?

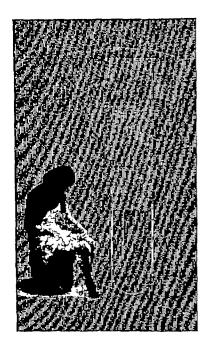
SPEAKER ANDRESEN Do you want to answer that?

DR GEIS Under a resolution that was adopted, I believe, last year by this House of Delegates and under a method of the State Board of Education there was a proposition introduced whereby graduates of unaccepted medical schools, Grade "C" schools, who had served in the armed services, in the Medical Department of the Army, Navy, or Marine Corps, upon satisfactory evidence of good work in such services and having received an honorable discharge, could be considered as candidates for medical examination and thus exceptions to the rule which provides that graduates of Class "C" schools are not admitted to our examinations That applies only to veterans of the war who served in the Medical Department of any of the armed services

DR FREDERICK A. WURZBACH, JR, Bronx And who are bona fide residents of the State of New York DR. GEIS Yes, who are bona fide residents of

New York

SPEAKER ANDRESEN There has been a suggestion made that we should act upon these recommendations in separate parts What is your pleas-



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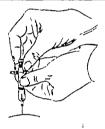
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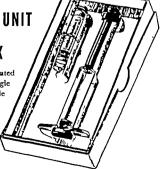
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Unconjugated ketocholanic acids (Ketochol) ntispasmones, generous diet of uncooked fats.

#### RESULTS

46.5° complete relief 46.5% partial relief 7.9% no relief

#### **AUTHOR**

DeLor C. J. Means, J. W. Shinowara, G. J., and Reinhart, H. L. Rev. Gastroenterol. 8:48 (Jan. Feb.) 1941

#### CONDITION

Noncalculous cholecystitis gallstone patients (poor surgical risks) cholelithussis without previous colle.

#### THERAPY

Ketochol, pland diet with uncooked fats, antispasmodics.

#### RESULTS

Satisfactory response to the medical regimen.

#### AUTHOR

Dolkart, R. E Illinois M J 87 43 (Jan.) 1945

#### CONDITION

Biliary constinution.

#### THERAPY



#### RESULTS

Prompt return of stools to normal size imme diste subsidence of other distressing symptoms.

#### **AUTHOR**

Gauss, H Am J Digest, Dis. 12,224 (July) 1945

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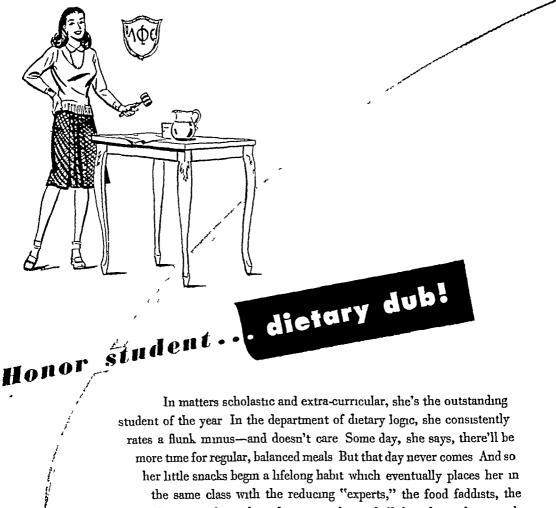
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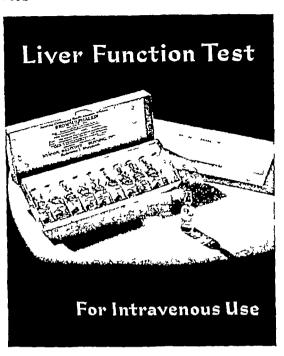
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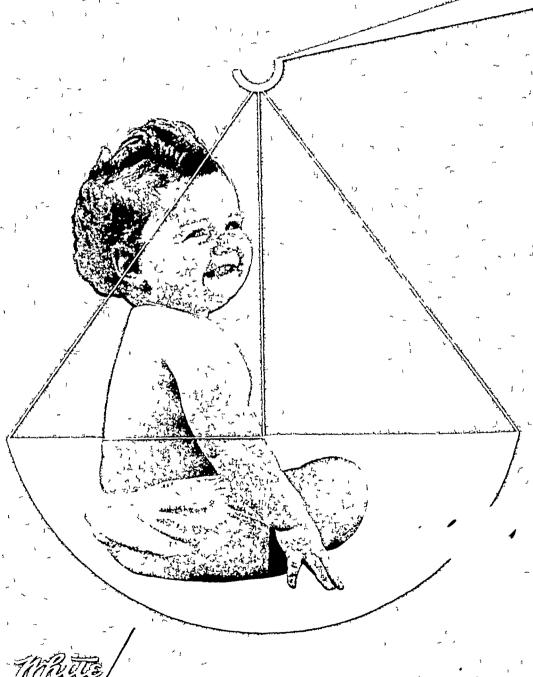
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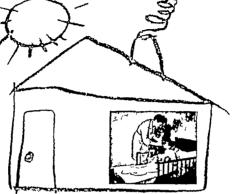
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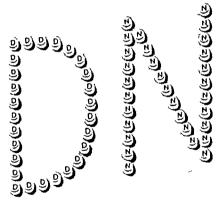
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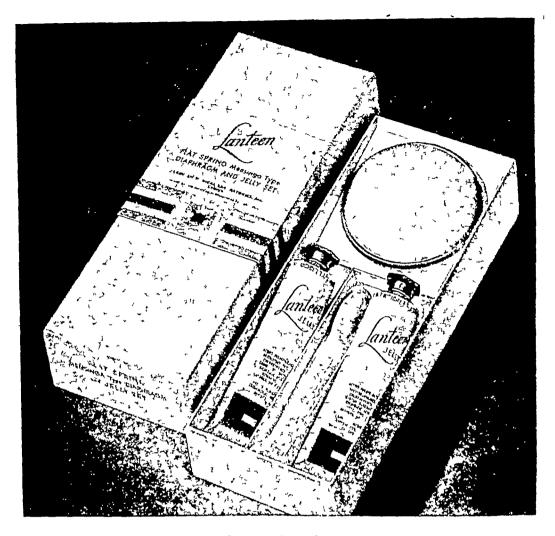
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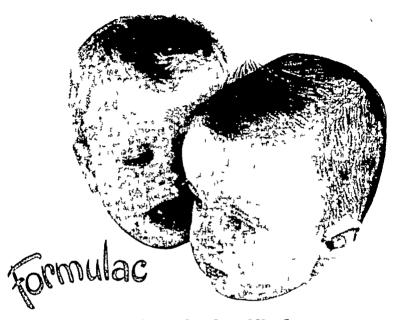
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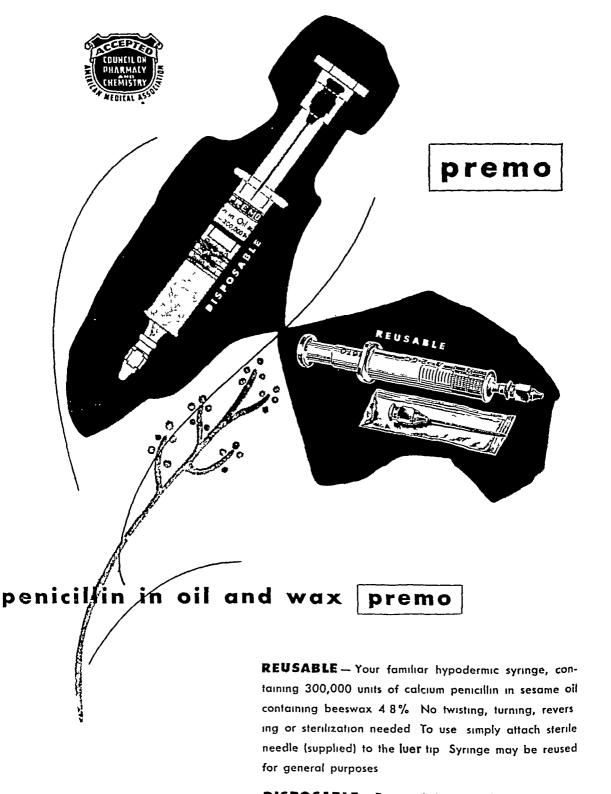
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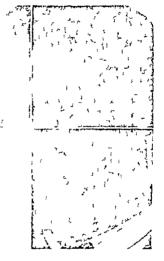
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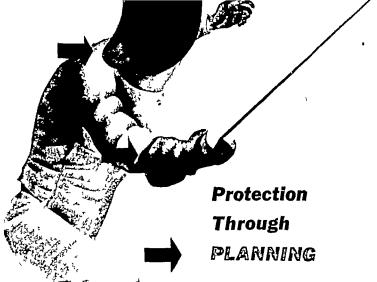
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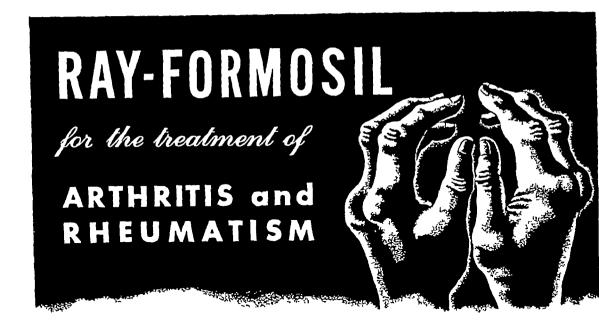
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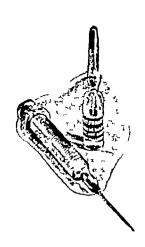
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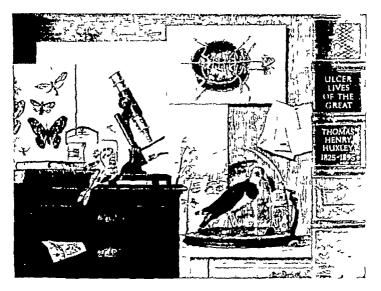
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VOLUME 47

OCTOBER 1 1947

NUMBER 19

## Editorials

## What Your Taxes Buy in Washington Federal Health Workshops1

Inordinate increases in Federal expenditures for publicity and propaganda led the Committee on Expenditures in the Executive Departments<sup>2</sup> to investigate activities of the United States Public Health Service, the Children's Bureau, the Office of Education. the U.S Employment Service, the Department of Agriculture, and the Bureau of Research and Statistics, in the Social Security Board, in connection with "health workshops" as set forth in our two preceding editorials. The Attorney General has been "requested to initiate proceedings to halt the use of public funds in this manner "\*

It would seem to be about time this were Regrettably we note the increasing tendency of certain departments of government to lend themselves to the propagation of philosophies and modes of conduct which do not seem consonant with the concepts and operation of a Republic That this is not done openly and above board but under the

cloak of what might well be a legitimate project of such an agency of government is the more disturbing by reason of the recent examples we have noted in Europe of subversive elements working within the framework of the historic or traditional or legiti mately constituted structure of government Such was lately the tactic of the Nazi party in Germany, such seems to be the tactic of the U.SSR, with respect to its satellite

The findings of the Subcommittee on Publicity and Propaganda of the House Committee on Expenditures in Executive Departments with respect to the "health workshops," involving at least six agencies of government, not only accuse these six Federal agencies of using government funds improperly for propaganda activities to "build up an artificial, federally stimulated public demand on Congress for enactment of the Wagner Murray-Dingell bill providing compulsory health insurance" but also raise the question who or what is behind such propaganda for socialized medicine?

The report of the investigating committees

<sup>1</sup> This is the last of a series of editorials on this subject. Prior editorials appeared in the September 1 and 15 issues.

1 House Report, No 785 80th Congress, First Session,
July 2 1947

1 J.A.M.A 134: 960 (July 13) 104\*

"invites particular attention" to the testimony and cross examination of the representative to the US Children's Bureau of the Federal Security Agency, "because we (the committee) feel that the devices and arrangements of Federal employment in this instance provide a typical example of how funds appropriated by Congress for the legitimate expenses of Federal agencies are diverted within the bureaus to full-time propaganda for socialized medicine"

We commend heartly the work of the Committee on Expenditures in Executive Departments for disclosing the improper use of Federal funds. The physicians of the State of New York will add their demand to the recommendation of the Committee that the Department of Justice initiate proceedings "to stop this unauthorized and illegal expenditure of public moneys."

We urge also that steps be taken by the appropriate committees of Congress to ascertain the influences at work within the six above-mentioned agencies of the Federal

government, and which may be responsible for the subversion of their proper functions and activity

Merely to stop the illegal diversion of public moneys without ascertaining why or at whose instigation the diversion was made, or in whose interest propaganda favoring compulsory health insurance or socialized medicine was to be disseminated by the device of the "health workshop" would be, in our opinion, to permit decay and rot to destroy eventually the structure of American life and government

If the American people want socialized medicine, they can obtain it in perfectly proper ways without the assistance of government bureaus

If they do not want it, they can clean out the group or individuals within the government who are spending public moneys in the attempt to create a fictitious sentiment for socialization, and find out why they are doing so

We strongly urge that this be done

## The Plethoric United States of America

The United States of America differs from almost every other country in the world in that at present it is in a state of plethora

We felt very happy about that statement until we looked up the word "plethora" in the dictionary and found that in colloquial parlance it means a "state of unhealthy repletion"

Then we began to wonder why we had made the statement From what we read in the papers it would certainly seem that we have more food, clothing, automobiles, houses, gasoline, oil, paved roads, roadhouses, liquor, moving pictures, shirts, shaving creams, and luxuries generally than any other country in the world

And yet for all these blessings we are not a happy nation Thumb through the morning paper any day and lot down on a sheet of paper the items you can find that would give anyone the slightest cause to be happy about anything

Suddenly it occurred to us what was the worst plethora—unhealthy repletion—with which this country was afflicted Education

Several hundred years ago education was a privilege It was something for which a few made tremendous sacrifices, and for those who made the sacrifices education earned them respect Like all privileges, it was early recognized as desirable and as such was seized upon and made the monopoly of a class—the clergy Harvard and Yale were colleges founded for the education of ministers, who, by the way, were very strong in the governing classes of their communities Loud were the howls that went up from the ecclesiastics when Thomas Jefferson came along with his "pernicious doctrine" of education for the masses

Jefferson had some sense He advocated elementary schooling for everyone He maintained that after a child had learned the "three R's" it might then be possible for his preceptors to decide whether or not he was fitted to pursue the higher learning, or whether he should be sent to a trade school How we wish that his counsels might have prevailed! We concede that there were flaws in them We doubt that,

at a given age, a child's true abilities can be judged by anyone. But we do think that in the vast majority of cases to a reasonable extent they can be. The true genius rises in spite of anything. If you don't believe us, we refer you to the obituary notices of Mr. Goudy, the type-designing genius who died recently.

A correspondent tells us of two halfwits who are the two happiest human beings he knows. They were early recognized as halfwits and no attempt was made to subject them to formal education. Both of them turned out "to have a green thumb" and as growers of vegotables and handlers of animals they are without a peer in their communities and are esteemed highly.

It seems likely that of all classes of people those engaged in the practice of medicine and its subsidiaries are suffering most acutely from this "permisious hypereducation"

The only sensible organization that our correspondent can think of is the French He was attached to it for six weeks. housed, appropriately enough, he remarks in the Insane Asylum of the Department of the Somme In the Insane Asylum he found sense, for the French Army Medical Corps was divided sharply into two classes. the Regulars and the Reserves. There was little love lost between them The Regulars, referred to by the Reserves as ces sales types d'actives, ran the hospital in all its ad ministrative details. The Reserve Officers did the operating Each did the task for which he was qualified. The results were excellent

How different, our correspondent remarks, from the practice in the Army of the United States, where a man might be promoted, because his mortality rate as an operator was extraordinarily low, to a rank in which he had no opportunity to exercise his operative skill and in which his ineptness as an administrator, to which his higher rank had doomed him, was equally extraordinary

Are we not pursuing exactly the same silly course, he asks, in our methods of education in medicine and its ancillary branches? There was a time when a gur enrolled in a training school for nurses because she wanted to look after sick people Where is she now? To begin with, she must have a college degree—With that indispensable preliminary she now aims at becoming a superintendent of nurses, a public health nurse, an official in the National Tuberculosis Association, the head of her own private hospital

We concede that we cannot go back to Jefferson's primitive ideas But can we not possibly arrive at some conclusions as to who is fit for what not exposing everyone recklessly to the dangers of higher education? Cannot we have courses for those who want to be just doctors or nurses, or trained attendants, or laboratory assistants? Cannot we reserve the somewhat questionable benefits of so-called busher education for those who have shown themselves to be qualified for it? Must we expose everyone to the test of the range on which we know very well that the targets are set too far for the majority of the candidates to hit? Must we send them through the rest of their lives with the tin can of failure tied to their tails, when we should have known well in advance that they should never have been allowed to try the impossible tests devised for them?

Doubtless, we shall be thought to be reactionary, but in this plethone country we submit we are in a plethora of higher education

We would remind our readers of the sound common sense of that old seventeenth century military song—"The merry heart goes all the way—the sad one tires in a mile-a."

We submit it is time to get rid of our plethora of "hypereducation" and to make the hearts of our students merry by setting them tasks graded according to their abilities, instead of making them unhappy by educating them for tasks for which any one with a modicum of sense could have realized they were inadequate

We end this editorial upon a note of sorrow We have spoken of a "modicitin of sense Who has one? We have also written as if we had a little more sense than others have, as if we thought we might be better able to separate the sheep from the goats than most of our qualified educators. We apologize We don't really think so

But we do know that if an unhappy fate had ever pitchforked us into such an awful responsibility as having to make lifelong decisions for other people, we should stress under-, rather than overeducation

The person who is exposed to higher education and is not qualified for it goes through life a disappointed and unhappy man has been given every opportunity for selfadvancement and has failed miserably

A person who has been undereducated and realizes it can always get more education Because he knows what he wants it for and appreciates the necessity for it. One who has been hypereducated does not know why and has been made permanently unhappy by having tools placed in his hands which he does not understand and will never know how to use Education for unhappiness is a terrible responsibility

## Current Editorial Comment

We have just had the some-Eugenics what dubious pleasure and privilege of reading an article entitled "Improving Genetically the World Population "1 We think it worthy of brief comment because it illustrates so perfectly the tendency of the brilliant mind to lose itself in the mists of speculation and to divorce itself totally from the real world

The article begins "Statement on the Genetic Improvement of Mankind" could not do justice to the article except by reprinting it in full, and we would not perpetrate that injustice upon our readers We lay ourselves open to grave risk by attempting even to abbreviate or summarize its ponderous absurdities

"One cannot compare the intrinsic worth of individuals 'without economic and social conditions which provide approximately equal opportunities for all members of society instead of stratifying them from birth into classes with widely different

privileges

"The removal of race prejudices and of the unscientific doctrine that good or bad genes are the monopoly of peoples or perwill not be possible before the conditions which make for war and economic exploitation have been eliminated This requires some sort of federation of the whole world

"This (the study of genetics) can, however, only come about when mens' minds are turned from war and hate and the struggle for the elementary means of subsistence to larger aims, pursued in com-

These statements—those who care to read them in full are referred to our footnoteare signed by F A E Crew, F R S, J B S Haldano, F R unheal Harland ML T

Leaning backward in our desire to be fair, we recall to your attention the fact that the article from which our excerpts are taken was written in 1939

What has happened since? est anti-eugenic world movement that has War—almost universal ever been seen War—the great scrambler of eggs alliances, casual or otherwise, the overnight stops or lifelong associations between the geniuses of one race and the morons of We venture to say that there is no proving ground like that of war Eugenical News may speculate as much as it pleases—or can afford to—about "Improving Genetically the World Population," but world upheavals such as we have witnessed and are now witnessing throw all their philosophic speculations into the dustbin

If the Eugenical News is really interested in genetics we refer it to serious breeders of animals Animals—dogs, horses, cattle, and such—are the only beings in this unhappy world whose breeding habits may, can be, and are controlled by man

The Mormons tried in their polygamous society to breed to one strain—the financially successful male Every man was required to impregnate as many wives as he could support Their polygamy was not a matter of lust, but of economics The Mormons' skeptical neighbors found difficulty in understanding that, and they were not long allowed to continue the practice

The only intelligently practical comment we have seen on the subject of eugenics was the reply of an old French nobleman who was asked by his grandson, "Grandfather, what did you do during the Revolution?"

"My boy," he said, thoughtfully, "I survived"

Eugenical News 24 63 (Sept ) 1939

## Scientific Articles

## AN EVALUATION OF ANESTHESIA WITH PENTOTHAL SODIUM, NITROUS OXIDE, AND ETHER

PAUL W SEARLES, M.D., MS Buffalo, New York

(From the Department of Anesthesiology University of Buffalo)

A CONSTANT search is being made for the ideal anesthetic. In my exponence the combination of sodium-pentothal, nitrous oxide, and ether provides a general anesthetic which approaches the ideal.

The selection of pentothal-sodium and ether was based on previous experiments on dogs which led me to believe that the barbiturates possess a tendency to protect the animal organism against the toxic effects of ether. In these experiments it was revealed that ether caused a concentration of the blood whereas the barbiturates produced a dilution of the blood. Nitrous exide was included in the combination to secure a deeper anesthesia during induction with sodium pentothal and allow for an earlier introduction of ether.

Impetus was given to studying the combined anesthetic effect of pentothal-sodium, nitrous oxide, and ether because of the author a experience in World War II Cyclopropane was unavailable to the majority of the US armed forces in the European Theatre therefore, sodium-pentothal was used to secure a quiet and rapid induction One form of anesthesia used in England consisted of a single large dose of pentothal-sodium for in duction followed by maintenance with nitrous oxide It was felt by most of the ancethetists in the U.S armed forces that a far eafer and a more satisfactory anesthesia could be obtained by the use of fractional doses of pentothal-sodium for induction followed by a maintenance with nitrous oxide and intermittent injections of sodiumpentothal The latter combination provided a light surgical anesthesia for extremity work and other operative procedures of longer than onehalf hour duration requiring only moderate amounts of relaxation. Ether was added to this combination whenever relaxation was desired The method proved very entisfactory especially on the Continent when temperatures were low and inductions were difficult

It has been my expressed purpose, since the termination of hostilities, to study and evaluate the combination of pentothal-sodium, nitrous oxide, and ether anesthesia in all types of individuals coming to surgery and to determine any detrimental effects attached to its use

#### Administration

The preoperative medication in good risk patients between 18 to 60 years of age consists of morphine sulfate grains ½ (0 01 Gm) and atropine sulfate grains ½ (0 0006 Gm.) given one hour before operation. Pentobarbital sodium (nembutal) also is administered in 1.5 grain (0 1 Gm) doseage one hour before operation in very excitable or robust patients. Many of the untoward effects of this combination of anesthetics can be traced to improper preoperative medication

The patient is induced by the intermittent or fractional injection of sodium-pentothal in a 2.5 or 4 per cent solution. With the onset of un consciousness nitrous oxide in approximately an 80 per cent concentration and oxygen in a 20 per cent concentration are administered by a mask from a standard anesthetic machine, employing carbon dioxide absorption When sufficient depth of anesthesia is obtained, for example second plane surgical anesthesia, ether is slowly added and increased to a position on the ether gage where one half of the gases are passing through the ether container. It should never be necessary to turn the other on full If the other is well tolerated the nitrous oxide is reduced and the oxygen increased to a point which allows for a minimum concentration of 30 per cent oxygen When relaxation has been obtained, the amount of other is decreased. If more relaxation is desired during the maintenance of anesthesia, 1 to 2 cc. (25 to 50 mg) of a 25 per cent solution of sodium-pentothal are injected and the other again increased to a position on the ether gage where one half of the gases are passing through the ether container. The resultant depressed respira

Presented at the 141st Annual Meeting of the Medical Society of the State of New York, Section on Anestheriology May 7 1947 Buffalo

tion from the injection of the sodium-pentothal must be "reinforced" by manual pressure on the Relaxation and a quiet field is breathing bag obtained readily and quickly In some instances an apnea is produced either purposely or coincidental with the administration of the anesthetic This appears due to the depressant action of sodium-pentothal on the respiratory center and to the washing out of the carbon dioxide by hyper-When this occurs, "controlled" respirations should be immediately carried out by manual pressure on the breathing bag It must be emphasized that "reinforced or controlled" respirations greatly increase the amount of ether entering the blood stream, therefore, the ether must be reduced in amount or completely shut off when using these technics Respirations may be quickly restored to normal by emptying the breathing bag of the anesthetic and refilling it with oxygen This procedure will allow the carbon dioxide to accumulate providing the carbon diovide absorption chamber is shut off completely Ten per cent carbon diovide in oxygen or a respiratory stimulant such as nikethamide, metrazol, or picroto in may be used but is seldom

The postoperative period is marked by a minimum of anesthetic complications and sequelae Recovery is rapid, providing the dose of pentothal-sodium has been small. Return to conclousness is quiet and pleasant with a minimum of mucus, nausea, and vomiting. Pulmonary complications, including atelectasis, are reduced because of the small amounts of mucous secretions.

#### Indications

It is my purpose to suggest that intravenous anesthesia with pentothal-sodium can be used in major abdominal operations requiring relaxation, providing that it is used in combination with nitrous oxide and ether. The method is also applicable to chest surgery where quiet and, at times, "controlled" respirations are necessary. In general, with few exceptions, when ether is the anesthetic of choice, a more satisfactory and adequate anesthesia will be secured by the use of this combined method.

#### Contraindications

It is well to avoid the use of the combination of pentothal-sodium, introus oxide, and ether in patients with cardiac history. This is true especially in patients suffering from dyspinea whether it is of a cardiac or pulmonary origin. Children under ten years of age offer a contraindication to the method because of the difficulty in making a venapuncture and instability of their respiratory mechanisms. It should not be used in patients with severe liver damage because they

tend to have a long recovery period after the administration of a barbiturate such as pentothal-sodium. Special care must be taken in the administration of this method to old patients as only small doses of these agents are required to produce anesthesia. Caution should be used in the administration of this combination of anesthetics in alcoholics. The alcoholic may require an excessively large dose of pentothal-sodium for induction and the result may be a long post-operative depression. In general, any contraindication to pentothal-sodium, nitrous oxide, or ether when employed alone will apply to their combined use

## Complications

A marked fall in blood pressure occurred in three cases, two of which had an existing hypertension and a third a cardiac arrythymia. In all three cases the ether had been turned on full and left on after the administration of sodium-pentothal. Shutting off the ether and refilling the breathing bag with 100 per cent oxygen restored the blood pressure in the two cases and abolished the cardiac arrythymia in the third case. Frail or poor risk patients also showed small drops of 10 to 20 millimeters of mercury in systolic pressure. These small drops could be remedied by adequate ventilation and oxygen.

Hiccups occurred infrequently but when present proved troublesome to the surgeon However, the luccups were relieved in all cases by the intravenous administration of an additional dose of 1/150 grain (0 0004 Gm) of atropine sulfate and by allowing the carbon dioxide to accumulate in the breathing bag Coughing and laryngospasm occurred occasionally and in most instances were due to the premature introduction of ether or an airway during induction Treatment consisted in removing the mask and pulling the tongue forward, or in the more protracted cases of administering atropine sulfate grains <sup>1</sup>/<sub>150</sub> (0 0004 Gm) intravenously The insertion of an intratracheal tube and artificial respiration were employed in only one case

#### Discussion

The ideal general anesthetic should possess the following characteristics—a wide safety margin, a rapid pleasant induction, adequate relaxation, quiet operative field, and an early pleasant recovery with a minimum of postoperative anesthetic complications—Pentothal-sodium provides a satisfactory induction and a quiet operative field—Nitrous oxide when administered with adequate oxygen in this combination adds to the anesthetic effect and fulfills all the characteristics except that of providing relaxation—Ether succeeds in fulfilling all the requirements when used

in combination with pentothal-sodium and nitrous oxide. The safety margin of these three popular anesthetics is greatly increased because the dose is less in this combination then when any one of them is used alone.

The use of the barbiturates as protective agents against the toxic effect of certain anesthetics is well-established clinically The barbiturates are employed as antidotes in the treatment of convul sions caused by the toxic effects of cocaine, nova caine, and ether Also the barbiturates are used in preoperative medication to allay excitement prior to induction of a general anesthetic. This excitement together with the administration of ether tends to cause a contraction of the spicen, resulting in a loss of reserve blood supply fore, it seemed advisable, both to further reduce the excitement and to counteract some of the toxic effects of ether, to induce the patient with a barbiturate such as sodium-pentothal

The rapid relaxation obtained under 'rein forced or controlled" respirations is most unlikely due to flooding of the brain with ether It is not necessary to administer large amounts of other to produce this relaxation In fact, great care should be exercised to avoid high concentration of ether to prevent the administration of an overdose It should be pointed out that many of the deleterious effects of ether come from using highly concentrated mixtures which are very irritating to the mucosa and produce excess mucus and respiratory difficulties In compari son the amount of ether used with the combination of pentothal-sodium, nitrous oxide, and ether is reduced to one half of that necessary with a nitrous oxide-ether sequence

The average dose of sodium pentotial is small when used with introis oxide and other. The dose varies from 0.7 to 1.0 Gm, the greater part of which is administered during the induction. When using the 'controlled' technic of anesthesia with this combination of anesthetics respirations return rapidly once the carbon dioxide balance is restored. For this reason, it might be assumed that the small amounts of sodium-pentotial administered during the maintenance are destroyed fairly quickly.

#### Summary

The use of intravenous enesthesis with pentothal-sodium is not confined to minor operations. Pentothal-sodium when used in combination with nitrous oxide and ether can be employed in major operative procedures requiring muscular relaxation. A quiet induction and adequate relaxation were obtained in all types of surgical operations. "Controlled" respirations can be obtained easily during the combined uso of pentothal-sodium, introus oxide, and ether anesthesia. The dose of any one drug required in this combination of anesthetics is less than when used alone, for this reason, and because the barbiturates protect the patient against the torue effects of ether, the patient recovers earlier with less deleterious effects.

#### Discussion

Dr Hubbard K. Meyers Buffalo —I would like to emphasize the point concerning the reduction in total desage of the agents used, which I believe is very important, especially in the aged and poor risk patient.

It would seem that the combination described is about as close to the ideal general anesthetic that we have today However I should like to mention a modification with the addition of another agent which I have employed I refer to induction with sodium-pentothal and maintenance with nitrous oxide and oxygen and other in the first plane of sur gical anesthesia and the addition of curare for necessary relaxation. It has been my experience that nationts react more readily after this sequence often at the conclusion of the operation or when being lifted onto the litter. The dosage of curare is regu lated to produce proper relaxation and is, of course usually less than when ether is not used but with the very small amount of other necessary to maintain light surgical anosthesia, dosage often amounts to 80 or 100 units. The use of curare also aids in overcoming or preventing laryngospasm if it should occur due to the irritating effect of ether or traction refloxes

Dr Searles stated that he believed that his method was contraindicated in patients with a cardiac history. It has been my belief that a cardid quiet calm induction with sedium pentothal with the addition of a 50 to 50 mixture of nitrous exide-exygen and other is to be preferred to a stormy struggling anoxic induction with mitrous exide-exygen and other or drop-ether in a cardiac patient. I should like to ask for comment on this point.

It would be interesting to know also if the author considers it necessary to intubate patients routinely in those to whom he expects to utilize the tochnic of controlled respiration in order to provent distention of the stomach with anesthotic gases.

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## THE TREATMENT OF INTRACTABLE PAIN

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(From the Gallinger Municipal Hospital)

THE traditional role of the anesthetist is in the relief of pain during surgery. The interest in pain itself, however, is much broader. The anesthesia service should be asked to help with the management of pain on any other service whenever this symptom is a significant factor in the disease.

All are agreed that no other symptom is so often the cause of medical attention being sought. The specialist then, who would concern himself with the broad aspect of pain, must classify it and develop a rational approach to the many clinical types. The most important teamwork is that between the anesthesiologist and the neurosurgeon, for it is to the latter that intractable cases must usually be referred. This teamwork has been carried through in the authorship of this paper.

In discussing the nature of pain Wolff¹ properly stresses the two phases. Pain perception depends upon threshold and varies only within narrow limits. Reaction to pain is individual and varies greatly. Two patients may have the same measurable perception threshold. The first may have little response to a given painful stimulus. The second may over-respond tremendously, and the response itself, with increasing tensions and lowering of conscious control, may add to the pain. It is physiologically true that the person who refuses to react to pain will have less

On a general medical service there are many occasions when pain relief has real curative value in disease. In coronary occlusion the great pain increases metabolism and ovygen requirement at the time when the myocardium may be unable to respond with increased circulation Complete rest with pain relief in a few minutes may be lifesaving Though less hazardous to life, the pain of gallbladder or kidney colic may seem as serious to When the immediate relief of great the patient pain is important, the proper treatment is the intravenous injection of narcotics There are three advantages to this method of administration Response is rapid enough that dosage can be properly graded and, therefore, made safer dosage is much less The rapidity of effect makes the patient conscious of improvement so that much less elevation of the pain threshold may be effective Seven to 10 mg of morphine intravenously may give more pain relief than several 15 mg hypodermic injections at half-hour intervals

On the surgical service and outside of the operating room, pain relief may be critical. After surgery of the chest or even upper abdomen, wound pain may prevent the patient from coughing or breathing deeply enough for minimal safe ventilation. Pain relief by narcotics may obtuind the cough reflex and depress respiration even further. On the other hand, simple intercostal block with procaine may reverse a downhill progress in a matter of minutes. Also the intravenous use of alcohol often may prove valuable

Pain is usually associated with circulatory impairment. Many factors have contributed to the present wide consciousness of the therapeutic value of appropriate sympathetic nerve blocks. Following the lead of Leriche, Ochsner and many others have used sympathetic blocks in the treatment of thrombophlebitis. Early pain relief has been one of the striking results. During the war, extremity injuries with attending vasospasm and pain were commonly repaired using regional block anesthesia. Not infrequently the operating team saw circulatory improvement as they worked, in some instances to the extent of reversing the decision to amputate

Pulmonary embolism is the outstanding example of vasospastic damage, potentially mortal Relief from pain and vasospasm by stellate ganglion block and efforts to maintain oxygenation may save some of these cases now lost

Although they quickly become too toxic to respond to it, patients with anuma from tubule blockage have significant early pain. Whether the anuma is due to transfusion reactions, to chemical damage, or even to persistent hypotension, all should have the benefit of splanchine block properly performed. Similarly, acute pancreatitis is indication for splanchine block.

Certain cases of severe dysmenorrhea will be relieved by low lumbar sympathetic block at the beginning of the pain cycle

It is not intended to imply that the pain itself is the dangerous factor in the foregoing discussion Instead, it is true that the earliest effective relief of the pain will tend to remove its cause and thereby become a fundamental form of therapy

By contrast with the above there are conditions in which pain may have lasted so long as to assume a significance out of all proportion to its threshold value. The value of pain as a habit is undeniable. The response even to a little pain may become maximal. For this reason the treat-

<sup>\*</sup> Presented by invitation at the 141st Annual Meeting of the Medical Society of the State of New York, Buffalo Section on Anesthesiology May 7 1947

ment of chronic pain with drugs to elevate threshold may be ill-advised unless the causative condition is cumble and short lived. If it is incurable, the relief of pain then becomes the principal clinical objective and early measures are justified to relieve the pain rather than merely to elevate the threshold to stimuli producing it

#### Case Reports

Case 1 —Measures which were too little and too late may be illustrated by a patient with herpes zos-A 42-year-old white woman had been treated for herpes of the left iliac region for two weeks by analgesics and lotions As the cruption receded the pain seemed to increase A competent neurologist used nerve block therapy finally culminating in a paravertebral alcohol injection. For the neuritis which resulted chordotomy was later performed with temporary partial relief Three years after the origin nal lesion this patient was turned down for subarachnoid alcohol injection because she was ambulatory with good rectal and bladder control most the only measure left is prefrontal lobotomy It is natural to speculate on the difference in course if paravertebral procaine block had been used at the beginning of the pain

Case 2 - A white woman aged 62, was seen for perineal and hip pain secondary to carcinoma of the uterus with extensive pelvic fixation. We were becoming interested in ammonium sulfate intrathecally and tried it on her following the technic of Judovich . This procedure was employed three times in the fall of 1944 with partial relief each time of less than two weeks. Subsequently various ones of the sacral nerves were blocked at frequent intervals using procaine anucaine and 95 per cont alcohol. Epidural block with 1 per cent ammonium sulfate was done several times. Most of these steps were helpful but very short lived. For two years a retention catheter has been necessary because of tu mor encroachment on the bladder A permanent colostomy was done fifteen months ago Hemor rhages severe enough to reduce hemoglobin below 50 per cent have occurred more than a dozen times. Seven months ago alcohol in the third and fourth sacral nerves produced a neuritis relieved only by subarachnoid alcohol block. Four subsequent repetitions of this latter procedure have maintained fair comfort to the present time

Obviously this patient should have had bilateral chordotomy three years ago. It was rejected by several consultants on the grounds that she would live only a short time. At present she walks to her car to go home to dinner three days a week. This patient has been the recipient of nearly every procedure we know in block therapy.

Case 3—A 28-year-old white woman had received nearly every possible form of orthopedic ther apy for pain in the right thigh posteriorly Marked relief followed caudal block with 1 per cent procaine 30 cc. followed by 30 cc. normal saline to increase the fluid pressure There had been no recurrence six months later This nonspecific response is pussling but is a clinical fact in a few cases

Case 4-1 64-year-old white man explored for

advanced hypernephroma on the left had severe postoperative pain Paravertebral block of D<sub>18</sub>, D<sub>11</sub>, and D<sub>21</sub> using anucame and repeated in two weeks gave reasonable comfort for the remaining any weeks of life

Case 5—Diagnostic sympathetic block as a preliminary to specific surgery is a worth-while procdure However, it can be misleading A 32-proceddwhite woman had had a protruding lumbar disk removed which was thought to be the cause of pain in the left leg. The operation was unsuccessful and was repeated some months later. However the pain soon recurred, perhaps worse than over A left umbar sympathetic block with procaine gave dra matic rollef. The same result was obtained by repetition of the block a week later. Left lumbar sympathectomy gave vascular rolaxition but the pain was unaffected. Probably the nerve block affected the paravertebral roots as well as the sympathetic trunk and thus was more extensive than the surgery

These cases illustrate the variety of the problems in nerve block therapy as well as the difficulty of obtaining good results

In the recently-established pain clinic at the Gallinger Municipal Hospital we are obtaining acceptance of a routine management, as Roven stine did in 1936.

The first essential is that a tenable working diagnosis be established. Second it is stressed that the effectiveness of pain relief is proportional to the speed with which it is instituted. This is especially true of the acute, severe pains. Here treatment should be initiated by elevation of the pain threshold by the use of intravenous morphia. The usual medical or surgical management will be adequate beyond this point in the case of such conditions as coronary occlusion gallbladder or kadney colle and traumatio injuries.

Nerve block therapy should be considered for all chronic pains of a localized nature and for conditions due to visospasm. The first step is the effort to localize the pain as narrowly as possible by the use of procaine. If the pain can be controlled by the use of procaine without undesirable motor effects, longer lasting agents should be used. Procaine in oil will give the same effect as aqueous procaine but for days or weeks instead of hours. If effective procaine block involves undesirable motor effects, the best agent to try is ammonium sulfate?

Alcohol is reserved for terminal incurable disease and for the cases where injection can be made to involve only sensor, or sympathetic fibers. Some comments on technic are in order Procaine is generally employed in a 1 per cent solution. Care to achieve accuracy of placement and injection of small amounts will improve results. These factors have been stressed by many workers since Labat's pioneering in the twenties. When oily solutions are used, aspesis is essential because of the infection hazard.

Since Judovich and his coworkers showed that the ammonium ion is the active principle in pitcher plant extract. there seems little reason to use the more complex mixture Furthermore. few will be prepared to make their own solutions of ammonium sulfate or chloride Through the courtesy of Dr George Hazel of the Abbott Laboratories we have used ammonium sulfate in sterile amoules The intrathecal injection of 250 to 300 mg ammonium sulfate in 30 to 40 cc spinal fluid has been used nine times and discarded because good results occurred only five times and lasted only three to five weeks, and because the immediate reaction was so great cases had headache and at least some nausea and vomiting This corresponds to Hand's experience 10 We have had as good results in cases of pelvic pain using 20 to 30 cc of 1 per cent ammonium sulfate in the caudal canal following the injection of 15 cc of 1 per cent procaine for early We accept the statement that the analgesia ammonium ion in this concentration does not affect sympathetic fibers and that, therefore, it is important to use it for somatic types of pain with associated segmental tenderness

In late carcinoma with pelvic pain the subarachnoid injection of alcohol is often indicated 11 For perineal pain we have modified Doghotti's method by introducing a Tuohy catheter into the spinal canal with tip passed caudad as far as possible X-ray films are taken to prove that the catheter tip is in the sacral region after which the patient is placed prone in bed with buttocks elevated on three pillows Absolute alcohol injected slowly will stratify above the spinal fluid more certainly than when allowed to float up from a needle tip The canal fills from the caudal end so that accurate judgment of amount is possible These catheters vary in contained volume from 01 to 03 cc and allowance for this must be made in accurate measurement of injected alcohol A half cc will give perianal and perineal anesthesia. One cc will extend forward to the urethra and to the lower Up to 11/2 cc and possibly more will spare leg muscle control Since most of these patients already have bladder and rectal damage, often with colostomy, the larger dosages can be employed and still keep them ambulatory have used this catheter method seven times and believe it to be an improvement for perineal pain

In general the use of subarachnoid alcohol should be reserved for those patients who are not considered safe for surgery or in whom a downhill course is quite rapid

## Neurosurgical Considerations

The neurosurgery of pain is an essential continuation of nerve block therapy in many cases

and for some should be the first consideration. The points outlined on the preceding pages are of real importance at this time, when more and more patients are developing degenerative and malignant diseases so frequently complicated by unbearable and often widespread pain. They should be of equivalent interest to the neurosurgeon and the anesthetist because of the close cooperation which should exist between the two specialties in an attack upon pain as a primary problem. The development of "pain clinics" in medical centers should be sponsored by both specialties, for a division of labors is becoming increasingly necessary in order to offer adequate therapy to sufferers

Pain-relieving procedures are essentially destructive, but this should not mitigate nor prevent their usefulness in rendering the agonized existence of a patient bearable once again, if only for a few short weeks. Each moment of severe pain seems like an eternity, as we all know, and we also know from physiologic experimentation as well as personal experience that there is little or no accommodation of the organism to pain, and that each new painful experience is as severe as the one preceding. Leriche said that the only pain which is borne easily is that in someone else. On most neurosurgical services, cases of intractable pain are considered as surgical emergencies, as they properly should be

The approach to the relief of pain may be made at one of several levels It is the intention of the surgeon to break the circuit of electric impulse Most peripherally, pain receptors may be isolated from their central connections by interruption of the peripheral nerve (cranial or spinal) infiltration of one of the three divisions of the trigeminal nerve at the point of emergence from the skull may eliminate the paroxysmal attacks characteristic of tie douloureux for many months, or may free a patient with carcinoma of the tongue or law from pain for the remainder of his Crushing or division of the sensory nerves in the leg can do much to ameliorate the painful features of Buerger's disease Recently, chronic visceral pain has been treated successfully by resection of the major splanchnic nerves and tenth to twelfth thoracic sympathetic ganglia, Lumbar sympathectomy long has bilaterally been known to be effective in relief from causalgia, and is often equally efficacious in treatment of ischemic pain in the leg due to vascular disease

Rhizotomy (division of the nonmyelinated axon of the peripheral sensory ganglion) is more permanent in its effects, because of prevention of regeneration of pain-conducting filaments. Retrogasserian neurotomy is the procedure of choice in the treatment of trigeminal neuralgia, and there is no recurrence of the condition. Dorsal intraspinal rhizotomy can eliminate the neuritis which

may be an aftermath of injuries to the chest, abdomen, or extremities or may complicate surgical procedures such as thoracoplasty Extensive. bilateral rhizotomy has been employed successfully in cases of intractable cardiac angina, al though resection of the inferior cervical ganglion with upper three thoracic sympathetic ganglia on both sides, as advocated by Olivecrona, 12 is a procedure less formidable in a poor cardiac risk

Chordotomy, introduced at the suggestion of Spiller 12 has proved to be an effective attack upon pain at an intermediate level By this operation pain-conducting tracts in the anterolateral superficial columns of the spinal cord are sectioned and touch fibers travelling largely in the postenor columns are spared so that complete anesthesis of the part of the body rendered painfree does not result. It is most useful in cases of pain of one lower extremity or of one half of the body below the umbilious, when umlateral chordotomy may be sufficient

If a malignant condition exists in the abdomen or pelvis, however chordotomy should always be bilateral. In the latter instance weakness of the legs and bladder difficulty may be troublesome for some time. Section of the spinal root of the trigeminal nerve in the medulla, a procedure devised by Sjoquist,14 is an equivalent operation for relief of pain in the face, for touch is again preserved in the areas partially denervated. When malignancy is invading the face and neck, such medullary tractotomy may be combined with rhisotomy of the upper cervical nerves on the affected side

Very recently prefrontal lobotomy, originally introduced by Freeman and Watts18 to the treatment of mental disease, has been extended to the problem of organic pain. It is best suited to the case of widespread or manifold pain with malig nancy, or may be used when pain involves the neck and arms It is effective by its prevention of pain from becoming a psychic experience, and is the most successful approach to the elimination of prin at the highest level Resection of portions of the postcentral (sensory) cortex corresponding to divisions of the body afflicted has been advocated by de Custerrez-Mahoney " Thus procedure involves the elevation of a large bone-flap under local anesthesia, an experience deflicult for a debilitated and often elderly patient to bear and while successful in the hands of the surgeon devising the operation in the experience of the writer has proved ineffective in the elimination of true in the face even when carried out bilaterally

The contention made that direct intervention into the pain-conduction system is superior to rehance upon elevation of the pain threshold by the administration of analgesics cannot be emphaauxed too strongly Many physicians feel reluctant to consider neurosurgical procedures in cases of intractable pain because of the obvious limita tion of the patients life by the fundamental pathologic process and because these cases seem to be such poor surgical risks. Each one of us has seen an individual tortured by an invasive carcmoma live far beyond the span of life allotted by the most sapient prognostician While neurosurgeons believe themselves to be as cautious and conservative as other surgical specialists, we are more accustomed perhaps to operating under adverse circumstances For these among other reasons, the sufferer should be given the benefit of consultation with the anesthesiologist and neuro-Proper cooperation between the two may do much to render the existence of this indi vidual bearable and even profitable once again

#### Summary

- The anesthetist should be concerned with the treatment of pain throughout the field of medicine
- Pain clinics should be set up for the orranged study of pain relief and the establishment of effective routines. They should be based on teamwork between anesthetist and neurosurgeon

Intravenous morphia is indicated for relief of acute pain

- Sympathetic nerve block should be used for severe vasospasm Included in this group of cases should be pulmonary embolism, persistent coronary spasm, anuma pancreatitis and throm bophlebitis
- Ammonium sulfate should be used in nerve block for chronic pain where important motor function is controlled by contiguous nerves.
- A catheter technic for the subarachnoid in section of alcohol is described
- The role of neurosurgery in the management of pain is outlined

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## DIFFERENTIAL SEGMENTAL SUBARACHNOID BLOCK A DIAGNOSTIC TEST FOR HYPERTENSION

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HERE are many causes of and diseases Associated with hypertension in man classified fifty of these causes and condensed them into five groups (1) renal, (2) cerebral, (3) cardiovascular, (4) endocrine, and (5) un-Some of the mechanisms thought to be responsible in this last classification are primary vascular disease. (2) increased sympathetic outflow from the cerebral cortex, and, (3) the presence of an angiospastic humoral substance

The surgical treatment of this unknown group, which comprises the greatest number of hypertensive patients, has received widespread attention in the past ten years. The surgery is primarrly intended to interrupt the sympathetic influences to the splanchnic and peripheral vessels Thoracolumbar sympathectomy is considered to be successful if it can produce a significant reduction in arterial blood pressure, relief in general disability, and improvement of evegrounds. cardiac, and renal function

White and Smithwick,2 Grimson,3 and Lord and Hinton strongly advocate thoracolumbar sympathectomy for hypertension Grimson<sup>3</sup> feels that this applies particularly to the neurogenic group and that more of the sympathetic chain has to be removed than is done in splanchnicectomy to abolish the postoperative fluctuations of arterial pressure Lord and Hinton and Smithwick have repeatedly reported the necessity of extirpating the sympathetic chain beyond the innervation of the splanchnic nerves

Numerous tests6-9 have been advocated for the selection of the hypertensive patient for surgery Methods have been proposed as a guide for the extent of sympathetic ganglionic resection, for example, the continuous caudal first suggested as a diagnostic method in 1945, and it was an attempt to indicate the effect of sympathetic depression at various levels upon the arterial tension. This procedure as described by Russek and Southworth<sup>10</sup> is not applicable to all With this technic the uncontrollable, rapid ascent of sympathetic depression from the tenth to the second dorsal segment, plus a concomitant muscular flaccidity, may be additional

Presented at the 141st Annual Meeting of the Medical Society of the State of New York, Section on Anesthesiology May 7 1947 Buffalo We wish to acknowledge gratefully the encouragement and assistance of Dr E H Campbell

high percentage of patients technical difficulties are often encountered because of abnormalities of the sacrum It is apparent that these procedures do not serve as an accurate guide to the surgeon. nor do they faultlessly evaluate the vasomotor activity of the patient

factors in the lowering of the blood pressure. In a

The purpose of this paper is to propose a subarachnoid sympathetic block, which will depress selectively and segmentally the vasoconstrictor fibers This test is not meant to serve as the only measure in evaluating the operability of the hypertensive patient, but as a means to determine the extent of resection of the sympathetic chain to produce a successful therapeutic result

## Method

The patient, not premedicated, is brought into a room heated to 90 F A lumbar puncture is performed between the third and fourth lumbar interspaces and set up for the fractional method of subarachnoid injection as described by Lemmon 11 The patient is then placed in the supine position and the intrathecal introduction of the drug is withheld until the completion of the control observations The control period consists of arterial blood pressure and pulse readings every five minutes over a period of one hour, or until the blood pressure is stabilized

The sensory dermatomes are mapped out with skin pencil over the entire body as described by Foerster 12 Regions within each dermatome also are outlined in order to confine the repeated examinations to a specific area The neurologic examination consists of appreciation or loss of pain, cold, heat, vibratory sense, and the degree of motor function of the legs Finally, the electric skin resistance is measured over the outlined sensory areas of the body with a dermometer, according to the method of Richter and Woodruff 13 14

After the completion of the control period, 5 cc quantities of a 0 4 per cent concentration of procame in distilled water are barbotaged at four-minute intervals into the subarachnoid space arterial blood pressure, pulse rate, and neurologic examinations are recorded every four minutes during the entire test When the sensory level of analgesia and level of sympathetic block reach the first dorsal segment, or, in the event of a significant hypotension, the test is concluded

The room is heated to produce an increased activity of all the sweat glands. This, in turn causes a uniform pattern of electric skin resustance over the entire body during the control period. In the surgical or functionally sympathectomized areas the sweat glands are inactive and this phenomena increases the electric skin resistance.<sup>12</sup>

#### Results

October 1 19471

Twenty four hypertensive patients selected as perspective candidates for thoracolumbar sympa theetomy were studied thoroughly by the departments of medicine and neurosurgery. After the completion of all other laboratory tests, these patients were referred to the department of anesthesiology for further evaluation by means of the differential segmental sympathetic block as was outlined previously. The effect of this test upon the functional activity of the sympathetic nervous system was determined qualitatively by the measurements of electric skin resistance. The onset of skin hypalgena and analgena was recorded at each dermatome and correlated with the arterial blood pressure.

These observations revealed that the levels of sympathetic block paralleled the level of skin analgesia, and that the depression of the activity of the sympathetic fibers followed from two to fifteen minutes after the onset of skin analgesia. In several instances there was a slight impairment of motor function of the lower extremities. In all the other cases there was no evidence of anosthetic depression of the motor nerves.

The results of this series of patients fell into three distinct groups Group I—no fall in ar terial pressure Group II—significant drop and Group III—moderate drop A significant lowering of the arterial blood pressure was judged to occur when the diastolic blood pressure fell to 100 mm Hg or less, along with a corresponding fall in the systolic measurement. When the systolic blood pressure fell appreciably, and the diastolic blook lightly or above 100, it was considered as a moderate drop. Table I illustrates the effect of this diagnostic measure upon the arterial tension at the various levels of sympathetic block. Five of the patients of Group II and one from Group I had bilateral thoracolumbar sympathectomies

TABLE 1 —EFFECT OF DIFFERENTIAL BYMPATRETIC BLOCK UPON THE BLOOD PREMEDER AT THE VARIOUS SYMPATRETIC LEVELS

Group	Blood Pressure	Sympathetic	Number of Patients
I	No drop	Up to T1	9
it A	Significant drop	From T10 to T6	2 5
ш о	Moderate drop	From T4 to T2 From T4 to T2	3

After reviewing the results, we noted with interest that it would have been possible to prophesy the postoperative course of the arterial blood pressure following thoracolumbar sympathectomy In several cases the sympathetic chain was excised several segments lower than what was determined by the test to be the optimum level The subsequent blood pressure was sustained within the same limits as obtained during the test at that particular seg mental level. In the other cases the resection of the sympathetic chain extended to the optimum level as indicated by the test. Again, the postoperative blood pressure readings fell to the same level as obtained during the block

The following case compares the results obtained by the differential segmental block with the sodium amytal test and the postoperative course

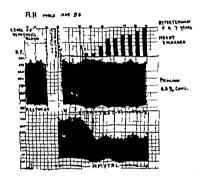


Fig. 1. This chart illustrates the comparison of the blood pressure obtained during the subarachnoid sympathetic block and the sodium amytal test.

Fig 1 illustrates the type of patient that fell into Group I The level of the sympathets block extended to the second thoracic segment Both the systolic and diastolic blood pressures were sustained throughout the entire diagnostic procedure, whereas a previous sodium amytal test produced a drop in systolic from 240 to 180 mm. Hg and the diastolic from 130 to 120 mm. Hg In other instances sodium amytal had no effect on the arternal tension and the differential segmental block produced a significant drop in blood pressure. We were not able to formulate any positive correlation between the sodium amytal test and the procedure that we report.

Figs 2 and 3 are graphs of the blood pressure in the resting state during the sympathetic block

and in the postoperative course.

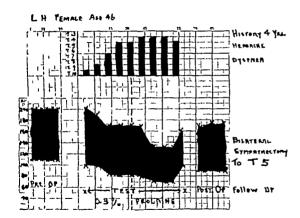


Fig. 2 This graph reveals the effect of the sympathetic block at the 5th thoracic segment upon the arterial blood pressure

In Fig 2 the sympathectomy extended to the fifth thoracic segment—Both the systolic and diastolic pressures are compared to that obtained during the test at the fifth thoracic segment as indicated by the dotted line—In this case the resting blood pressure of 200/110 dropped to 160/90, when the block reached T5—There was a further drop to 130/70, when the block reached T3—The postoperative blood pressure stabilized at 170/90

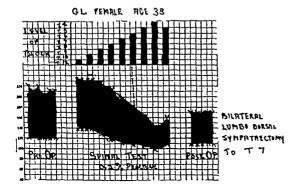


Fig. 3 The progressive decline in arterial blood pressure during the ascent of the sympathetic block is shown

In Fig 3 the resting blood pressure was 210/120 and fell to 180/110 when the segmental test reached the level of the sixth thoracic segment. When the block extended to the fourth sympathetic dermatome the blood pressure fell to 140/100. A bilateral thoracolumbar sympathetic ganglia and the postoperative blood pressure stabilized at 170/110. Here, again, the postoperative reading compared favorably with that obtained during the test, as indicated by a dotted line on the graph.

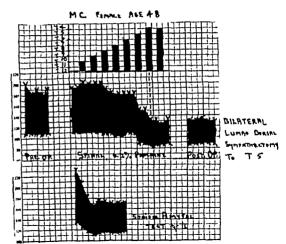


Fig 4 The blood pressures during the sodium amytal test and segmental sympathetic block and the bilateral thoracolumbar sympathectomy are compared

Fig 4 compares the blood pressure obtained during the sodium amytal test, the differential sympathetic block, and the postoperative period. This patient had a bilateral sympathectomy up to, and including, the fifth thoracic sympathetic ganglia.

During the sodium amytal test the blood pressure fell from 230/140 to 170/118 During the segmental spinal procedure the pressure dropped from 220/110 to 130/90 when the block reached the fourth thoracic dermatome The postoperative blood pressure of 130/90 again parallels that of the sympathetic block.

#### Discussion

The difference in susceptibility of the nerve fibers traversing the subarachnoid space to anesthetic drugs has been the subject of speculation for many years Tait and Caglieri15 demonstrated that weak concentrations of cocaine have a selective and preferential depressant action on the sensory nerves Heinbecker, Bishop, and O'Leary<sup>16</sup> reported that when a mixed nerve is infiltrated with a low concentration of procaine, the impulses carried by class C fibers are the first to disappear This work suggests that the phenomena applies to the smaller unmyelinated fibers which are found in both the sensory and sympathetic nerves Vehrs'17 clinical observations of controlled injections of low concentrations of procaine demonstrated the differential action of novocaine upon the sensory and sympathetic nerve fibers Sarnoff and Arrowood 18 have also produced a block of the sympathetic and sensory fibers without affecting the motor nerves Both Koster<sup>10</sup> <sup>20</sup> and Vehrs<sup>21</sup> have shown that from four to ten minutes after the initial subarachnoid injection of procaine the concentra-The above reports tion is greatly reduced formulated the basis for our use of weak concentrations of novocame the time interval between injections, and the method of administration of the drug

We have attempted to evaluate the effect of the intrathecal injection of procaine in low con centrations as a prognostic sympathetic block for patients with hypertension Repeated trials with 0 1 to 1 per cent processes were made. The volume of the drug that was injected at any one time varied from 1 to 8 cc. Subsequently it was found that 5 cc. of a 0.4 per cent solution of procaine injected every four minutes produced a more uniform action without suddenly "flooding," and depressing the upper dorsal nerve roots.

With our outlined technic it was possible to in terrupt the function of the vasoconstrictor fibers slowly and segmentally This, we feel, is very im portant, because sudden depression of a large part of the sympathetic chain will often produce a preapitous hypotension When the vasoconstructor activities of the sympathetic chain are depressed slowly, it is possible to correlate the resultant arternal blood pressure with the extent of the block. The determinations of the electric skin resistance by means of a dermometer verified the findings of Schumacher22 as to the level of the interruption of impulses of the sympathetic fibers

Admittedly, the number of operative cases are too few to evaluate conclusively the efficiency of this particular diagnostic procedure but we feel that it is highly suggestive as a valuable prognosto guide to the neurosurgeon

#### Summary

The intermittent intrathecal injection of concentrations of procaine ranging from 0.2 to 0.4 per cent over a period of an hour can produce a differential type of block. The sensory nerve roots and function of the sympathetic fibers are preferentially affected by this method

This paper is a preliminary report of a technic for evaluating the effect of sympathetic block on the arterial blood pressure of patients with hyper The functional depression of the sym pathetic chain was discerned by the measurement of electric skin resistance. The results of this test on 24 patients are reported

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#### PNEUMONIA IMMUNIZATION OUTS DEATH RATE OF OLDER PERSONS

A group of New York investigators who made a six year study of pneumonia in elderly patients, suggest immunisation against the disease where high incidence rates prevail as in epidemics, in institu tions, and in persons with a tendency to recurring pneumonia

Writing in the current issue of the Archies of Internal Medicine published by the American Medical Association, the investigators—Paul Laufman M.D., attending physician, Goldwater Memorial Hospital and Now York City Home, C. O Brien, M.D. resident physician, and Il Stein M.D., resident physician, New York City Home—state that they undertook their study in the older age group for several reasons

First, they have a high incidence of pneumonia, mortality and case fatality rate. Second, repeated attacks of pneumonia occur frequently Third there was possibility for continuous observation, hospitalization and re-examination since the patients were from the New York City Home and the Medical Division of the former Central and Neurological Hospital and the Goldwater Memo-

rial Hospital where higher age groups are treated.

During the six year study 1937 to 1943 5 750
patients were immunized against pneumonia while 5 153 control patients were observed for comparison 5 153 control patents were observed for comparison Among the immunized group 90 developed pneumonia, an incidence rate of 17.2 per 1 000, of which 40 dfed, a mortality rate of 6.2 per 1 000. There were 227 cases of pneumonia among the nonlimmunized patients an incidence rate of 44 per 1,000 with 98 deaths, a mortality rate of 19 per 1 000. The antigen used in these experiments for immunization is made from a fraction of the pneumonia with experiments are consistent to comparison.

mococcus, the organism responsible for pneumonia. The antigen, which incites production by the body cells of a substance to fight the bactera, is a polysacchande.—American Medical Association News

July 11 1047

# PHLEBITIS AND PULMONARY EMBOLISM FOLLOWING PENTOTHAL-SODIUM ANESTHESIA

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(From the Department of Anesthesiology, Temple University Hospital and Medical School)

In THE thirteen years since its introduction into the clinical practice of anesthesiology pentothal-sodium has proved to be a drug which is relatively free from untoward effects. However, certain precautions must be taken at all times if one wishes to avoid complications and if the drug is to retain its popularity. The major complications such as laryngospasm, respiratory depression, extravenous injection of the drug, and trauma to nerves of the arm are well known, but reports of phlebitis followed by pulmonary embolism have not been found in the literature

When pentothal was first introduced the concentration suggested was a ten per cent solution of the drug Within two years there were reports of phlebitis at the site of injection of the drug even though there had been no extravenous injection Reports of extensive phlebitis following injection of pentothal-sodium in 5 per cent concentration have appeared in the British In one case it was thought that literature pooling of the pentothal in the arm vein due to the position of the patient on the operating table There was no was a strong etiologic factor mention of pulmonary embolism in these cases 1-3 There were also occasional reports of sloughing of superficial tissues when extravascular injection did occur 4,5 These complications led quickly to reduction of the concentration from a ten per cent to a five per cent solution of pentothal which was widely used for several years Even with this concentration an occasional case of phlebitis did occur, the incidence of which Adams set at about one in one thousand administrations • Subsequently, Lundy and his group suggested the more dilute 21/2 per cent solution of pentothal not only to make this anesthetic drug safer for general use but also to avoid these annoying complications 7 This two and a half per cent concentration has proved to be a safer one from the viewpoint of both physician and patient in regard to the incidence of these potentially serious complications

During the past year two unusual cases of phlebitis following injection of pentothal have come to our attention. In addition to the phlebitis there was venous thrombosis followed by pulmonary embolism. These cases occurred in different hospitals.

## Report of Cases

Case 1 -This apparently healthy 49-year-old man was operated upon for removal of a small lipoma of the left posterior chest wall on July 27, 1946 Pentothal-sodium in a two and one-half per cent concentration in distilled water was the sole anesthetic agent used The supine position with a sandbag under the left shoulder was employed during induction of anesthesia but for the surgical procedure the right lateral position was necessary Venapuncture was made without difficulty in the right arm. antecubital space A total of 18 cc (450 mg) of the anesthetic solution was given during the operation Anesthesia and surgery were uneventful, recovery was not prolonged and the patient was discharged to his home within a few hours of completion of the operation Shortly after regaining consciousness the patient noted a stinging sensation in the right arm about the site of injection of the pentothal. These symptoms progressed during the next eight days with pain and tenderness of the anterior surface of the right arm and shoulder

On the eighth postoperative day, August 4, 1946, there was sudden onset of severe, sharp pain in the right lower chest anteriorly This pain was accentuated by deep breathing, later there was reference of the pain to the right shoulder He was seen by a physician who administered morphine (16 mg) and atropine (04 mg) within an hour after the onset of pain Medication of this type was continued for the next twenty-four hours in an effort to relieve pain and prevent spasm of pulmonary ves-A cough, which was productive of moderate amounts of thick, bloody sputum, developed within a few hours after the onset of pain Temperature was 100 3 F orally There was marked shortness of breath Physical findings soon after onset of acute symptoms consisted of diminished breath sounds and a few scattered crepitant rales by auscultation over the right postero-lateral aspect of the chest On percussion there was dullness over the same region. Examination of the right arm revealed a thin, linear zone of tenderness extending from the antecubital space into the right axillary fold anteriorly and even into the supraclavicular area. There was redness and induration along the course of the involved vein beginning in the antecubital space and extending upward for approximately 12 cc Moderate redness but no edema or induration was present at the site of the venapuncture

This patient became acutely ill with a spiking temperature up to 102 F. A bedside roentgenographic examination of the chest made one day after the onset of symptoms, August 5, 1946, revealed a "triangular area of increased density in the lower lateral portion of the right lower lobe. The base of this triangular area was adjacent to the pleura. There

Presented by invitation at the 141st Annual Meeting of the Medical Society of State of New York Buffalo Section on Anesthesiology, May 7 1947

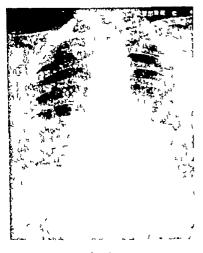


Fig 1

Fig 2

was some blunting of corresponding costophrenic angle with a small amount of fluid "These findings were considered to be suggestive of pulmonary infarction with associated pleuritic (Figs. 1 2)

A medical regimen of therapy was started using morphine and atropine as previously mentioned, penicillin prophylactically for pulmonary infection and anticoagulant drugs (heparin and dicumarol). The anticoagulant thorapy was continued for ten days and fever subsided gradually to normal in five days. The physical findings in the right arm disappeared during this time but the chest findings per sisted for approximately three weeks. After this time they disappeared gradually and recovery ensued without further incident.

Case 8 -A 47 year-old man was admitted to the hospital accident dispensary where a diagnosis of Barton a fracture of the right wrist was made July 25 1946 Treatment at that time consisted of encasement of the right arm in plaster from the midpalm to the midhumeral area. He returned four days later July 20 1946 for delayed reduction and fixa tion under fluoroscopic observation General anesthesia using pentothal-sodium in two and one-half per cent concentration was the only anesthetic agent recorded on the outpatient card but nitrous oxide and oxygen in equal concentration may have been administered No pre-anesthetic medication was used. The total amount of pentothal administered was not recorded. The operative procedure lasted thirty minutes and consisted of fixation of the fracture by means of pins and plaster cast. There was no difficulty in doing the venapuncture in the left antecubital space with the patient in the suping

position. Consciousness occurred soon after completion of the orthopedic procedure and the patient was discharged home within three hours. He later reported that there was some soreness at the site of injection of pentothal as soon as consciousness returned This continued extending up the left arm to the shoulder and persisted for the next thirty five days but no medical attention was sought. On the thirty fifth day September 2 1946 there was sud den onset of severe pain in the left lower chest accompanied by dyspnes and a mild cough. The latter was occasionally productive of small amounts of blood streaked mucus. He was admitted to the hospital three days after the enset of scute symptoms (September 5 1946) At this time physical examination revealed an acutely ill dyspneic patient with slight cyanosis. Temperature was 102 F There was limited motion of the left side of the chest many cropitant rales decreased breath sounds, and dullness to percussion on that side

There was marked tenderness of the left arm and shoulder and a thin linear zone of redness and in douration extended from the antecubital space to the axillary fold antenorly. Marked tenderness was found also in the left supraclavicular area sand surgical ligation of the involved vein was considered at that time to be contraindicated. There was a small area of redness about the original venapuncture atto but no edoma or induration was present.

Bedside v ray examination of the chest on the day of admission was unsatisfactory but did show areas of increased density in the bases of both lungs. However films taken five days later (September 10, 1946) showed increased density at both bases with a transgular area of consolidation extending from the heart border to the late.



Fig 3



Fra 4

on the left side The base of this triangle was at the lateral chest wall Some pleural reaction was noted at both bases" These findings were interpreted as showing multiple areas of infarction of the lungs with the greater involvement on the left side (Figs 3 4)

This patient was treated medically with anticoagulant drugs (heparin and dicumarol), penicillin prophylactically, and fluids by the intravenous route. Temperature spiked as high as 103 F but fell slowly to normal on the twelfth day of hospital care. Roentgenographic studies, three weeks after admission, showed "complete clearing of the right lung but there was still a large area of infarction at the left base"

The signs and symptoms in the left arm, shoulder, and clavicular area subsided in approximately fifteen days and the patient was discharged as improved twenty-three days after admission.

#### Discussion

A search of the literature has not revealed similar, serious complications even when the more concentrated solutions of pentothal were employed. The literature does reveal that phlebitis may occur rarely (1 in 3,000) when pentothal in two and a half per cent concentration is used but that it is usually a local reaction without further complications. Richards has reported that in experimental work local venous thrombosis is rare if the concentration of the pentothal solution when injected does not exceed two and a half per cent, but that concentrations between ten and

forty per cent can cause enough irritation of the intima of veins to produce thrombosis 8

In some hospitals the responsibility for preparing the stock solution of pentothal is placed upon one member of the anesthesia department However, in many other hospitals this responsibility is divided among staff anesthesiologists, residents, interns, and nurse technicians within the department. In the latter situation it is apparent that there is greater opportunity for error in preparation.

In the past year the authors have observed three stock bottles of pentothal-sodium solution in which the concentration of the drug at the top of the bottle varied considerably with that at the bottom These were tall bottles each of which contained 200 cc of sterile, distilled water and into which five grams of pentothal powder had been It was apparent that the bottles had not been shaken and that most of the pentothal remained in the lower half of the bottle in concentrated solution If one were to load a syringe by aspiration through a long needle which reached to the bottom of such a bottle, he would probably obtain a concentration of pentothal up to thirty or forty per cent Therefore, it is our feeling that the concentration of pentothal used in the above cases may have been in excess of two and a half per cent and may have been a causative factor for the phlebitis

#### Summary and Conclusions

- 1 Two cases of phlebitis and subsequent pul monary embolism following pentothal-sodium anesthesia have been presented
- 2 The incidence of phichits following pontothal anesthesia increases as higher concentrations of the anesthetic drug are employed
- 3 Varying concentrations of pentothal due to error in preparation of the stock solution have been observed

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#### DE SENECTUTE

The lines "Gather ye rosebuds while ye may" and so forth, familiar to all of us are still appropriate in these days of longer life but of accolerated living. They are, moreover by one who knew his old ago Robert Herrick having put eighty two summers behind him oven in the seventeenth century when the average span of man's life was well under forty years

Not only has the duration of life nearly doubled since the over-ripe Herrick wrote his somewhat amorous lyrics, as a result, the average age of the populations of civilized countries has likewise steadily increased. The old, like the poor will definitely be with us, and we must look to the better care of the aging, if they are to enjoy the fullness of their years. We must put more emphasis on the last of Shakespears a seven periods of customes if we are to try and save the "lean and slipper'd pantaloon from

Sans teeth sans eyes, sans taste sans everything

This interest in the problems of the old is fortunately quickening here and abroad to the point where geriatros, caring for the tapering end of the life line has become as serious a specialty as has pediatrics for its beginning. It is wise to bear in mind that the sunset of man a life may have as vivid colors as its dawn, and he is much more conscious of it.

As Dr Roger I Lee has pointed out we have, by our care of the young permitted many more people to become elderly without doing much to make that increase in years any happler or even more endurable. One of our tasks is to make these added years for which most of us hope and which most of us dread more pleasant ones to anticipate and to attain.

The declining years of life should have their own activities and their own compensations and their own type of oversight. They require certain dictary limitations, as of fats and roughage, and certain dictary reinforcements, as of vitamins and even digestants. Indeed some of the proprietary firms are already promoting pap for the aged as well as pap for the young.

Age has its dignity, too often lost, let it also have its comfort, too often lacking. Let our second childhood at least share the consideration given our first. The enthusiastic lines of Rabbi Ben Erra

Grow old along with mel

The best is yet to be, The last of life, for which the first was made,

particularly appropriate for a geriatric alogan hold a promise that is still not always fulfilled, but offers a target at which to shoot.—Educrial New England Journal of Medicine. June 3 1947

## PREPARING FOR WORLD CITIZENSHIP THEME OF 38TH MEETING OF NATIONAL COMMITTEE FOR MENTAL HYGIENE

The 38th annual meeting of the National Committee for Mental Hygiene will be held on Wednesday and Thursday November 12 and 13 1947 at the Hotel Pennsylvania, New York City Dr Georga S Botvenson medical director has announced. The two-day program will be devoted to mental hygiene issues in Preparing for World Citizenship as suggested in the preamble to the Constitution of the United Nations Educational Scientific and Cultural Organization which reads ince wars begin in

the minds of men, it is in the minds of men that the defenses of peace must be constructed.

The Lasker Award for this year's most significant contribution to popular adult education especially in parent-child relationships, will be presented at the annual luncheon meeting. November 13 An address will be given at this time on the responsibilities and opportunities of citizens and mental hygiene or ganizations in the states in terms of immediate issues to be faced.

## BRAIN TUMOR SIMULATING PURULENT MENINGITIS

Emanuel Appelbaum, M D , Jane W Norman, M D , and Jobl J Brenner M D , New York City

(From the Fourth Medical and the Neurological Divisions, Bellevue Hospital, and the Bureau of Laboratories, Health Department)

THE symptomatology of brain tumor is in certain respects similar to that of meningitis. Headache, vomiting, and a change in the mental state are symptoms common to both diseases. Even the important meningitic signs of fever and nuchal rigidity occasionally may be encountered in cases of cerebral neoplasm. It is not generally known, however, that in rare instances of brain tumor the spinal fluid may actually become purulent in character. The case about to be cited illustrates this important phenomenon.

### Case Report

History—P J, a man, aged 55, was admitted to Bellevue Hospital on March 11, 1946, complaining of severe frontal headache and pain in the back of the neck of two weeks' duration—Two days before admission the patient experienced some chilly sensations—Because of the patient's mental state it was not possible to obtain any further information

Physical Examination —On admission the patient was semistuporous but responded to commands and answered questions slowly He appeared acutely and seriously ill but was not in respiratory distress. The temperature was 101 F, the pulse 58, and the respirations 24 The blood pressure was 122 systolic and 72 diastolic No abnormal findings were noted. in his nose, ears, or pharynx Except for moderate suppression of the breath sounds in the upper half of the left lung there was no evidence of pulmonary disease There was a brady cardia but in other respects the heart was normal The abdomen was soft and the spleen was not felt. There was generalized muscular spasticity A slight left facial paresis, involving the lower two-thirds of the face, was noted A slight left facial paresis, Definite paresis of the extremities could not be made out, but when the arms were stretched forward there was drifting on the left side There was marked nuchal rigidity and positive Brudzinski and Kernig The right pupil was larger than the left, and easted to light and in accommodation. The both reacted to light and in accommodation deep and superficial reflexes were preserved, but the left abdominals appeared to be diminished. The left abdominals appeared to be diminished Babinski and confirmatories were all negative The fundi showed some narrowing and tortuosity of the vessels with increased light reflex but clear disks

Laboratory Data —The red blood count was 3,510,000 with 117 Gm of hemoglobin and the white blood count was 10,800 with 76 per cent polymorphonuclears. The urine showed 1 plus albumin but no other abnormal findings. The blood nonprotein nitrogen was 35 and the sugar 87 mg per 100 cc. A Wassermann test was negative. The spinal fluid was turbid and showed a large number of cells, 98 per cent polymorphonuclears, a protein of 320 mg, a sugar of 44 mg per 100 cc, and no organisms by smear or culture.

Presented at the New York Academy of Medicine Graduate Fortnight, Bellevue Hospital Clinic New York City October 15 1946

lungs and some thickening of the mucous membrane

of both ethmoids and the right antrum.

Treatment and Course—When a turbid spinal fluid was obtained a diagnosis of some form of purulent meningitis seemed warranted and intensive penicillin therapy was instituted immediately. The regimen consisted of a daily intrathecal injection of 200,000 units of penicillin and of intramuscular injections of 50,000 units of the antibiotic at three-hour intervals. This treatment was continued for about a week but it did not result in any improvement in the patient's condition. The semistuporous state persisted and the abnormal neurologic signs became somewhat more pronounced. In addition, he exhibited occasionally jactitatory movements in his left arm and left leg.

On March 15, the fifth day of admission, there was further progression of the pathologic signs. Particularly striking at this time were the fundus changes, which showed engorgement of the vessels and bilateral papilledema. As shown in the accompanying table, the spinal fluid findings remained essentially unchanged. The cells were too numerous to count and were predominantly polymorphonuclears. It is important to note that all the spinal fluids showed a normal sugar content and no organisms by smear or culture.

It soon became apparent that the clinical picture was not that of bacterial meningitis but rather of a reactive or sympathetic meningitis, secondary to some focal intracranial disease, probably a brain absecss in the right temporal lobe. The patient was transferred therefore to the Neurological Service

On March 19, ventriculography was performed through a trephine hole on the right side of the skull. The dura was tense and the brain herniated through the burr-hole Exploratory puncture of the right temporal lobe yielded a yellowish fluid. The ventriculogram (Fig. 1) revealed moderate aeration of the left lateral ventricle with moderate dilatation of the anterior and posterior horns. The left anterior horn was displaced to the left by a mass in the right anterior cerebral area. The third ventricle was markedly displaced to the left. The right lateral ventricle was not definitely visualized. There were quadrangular defects in the right parieto-temporal and frontal regions (burr-holes).

On March 20, a craniotomy was done and yellow-

On March 20, a craniotomy was done and yellowish gelatinous tissue, resembling in the gross glioblastoma multiforme, was removed from the medial portion of the right temporal lobe. The bone flap was left open for decompression. Following the operation the patient received a course of radiation therapy. For a while some improvement was noted in his condition, evidenced by a lessening of the stuporous state and a decrease in the papilledems. Soon, however, the severity of the symptoms in creased and the disease progressed to a fatal issue.

creased and the disease progressed to a fatal issue

Pathologic Report — Dr Lewis D Stevenson, the
neuropathologist, submitted the following report on
the microscopic examination of the tissue removed at
operation Tissue shows packed tumor cells rela-

2107



Fig 1 Ventriculogram shows the changes described in the text



Fig 2 Tumor tissue Section shows packed tumor cells relatively well-preserved with areas of necrotic cells (× 220)

tively w.ll-preserved with large areas of necrotic cells (Fig 2) There are many thick walled blood cossels, some entirely occluded by the thickening of the wall and some with the wall invaded by tumor tissue (Fig 3) The tumor cells appear to be sponguoliasts, of varying size and shape. Many plump astrocytes are present. There are some multinucleated forms, although these are not conspicuously large or numerous. Mitotic figures are not seen. The tumor should probably be classified as sponguo-blastoms multiforme

#### Comment

The patient's failure to respond to intensive penicillin therapy and the progression of the focal signs and of the papillodema within a relatively short time led us to suspect the presence of a brain abscess Furthermore the repeated spinal fluid examinations showing on each occasion a normal sugar and absence of organisms convinced us that the patient had a meningitis sympathica, secondary to focal intracranial disease. The presence in the right cerebral area of a space-occupying lesion was confirmed by the ventriculogram. However the finding of a brain tumor instead of an abscess was somewhat of a surprise

This case shows how meningitis sympathics may at times cause confusion in diagnosis, particularly if the meningeal reaction is pronounced. This condition is found in connection with brain abscess inflammation of the various sinuses of its media, mattoldits and on rare occasions it is associated



Fig. 3 Tumor tissue—Section shows thick walled blood vessels (× 135)

TABLE 1 - SPINAL FLUID FINDINGS

Date 3-11-46 3 12-46 3 13-46 3-15-46 3-16-46 3 19-46	Appearance Turbid Turbid Turbid Turbid Turbid Turbid Turbid	Cells  Large number polynuclears   Smear Negative Negative Negative Negative Negative Negative	Culture Negative Negative Negative Negative Negative Negative	Protein Mg % 320 203 146 167 165 192	Sugar Mg % 44 56 57 51 57 54	
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with brain tumor The typical symptoms of meningitis are usually present The spinal fluid is increased in amount, is hazy or turbid in appearance, shows an increase in polymorphonuclear cells and in protein, and a normal sugar. It is invariably negative for organisms Repeated spinal fluid examinations may be necessary before one can be sure that the condition is not an early stage of bacterial meningitis

In this connection it is necessary to point out that

meningitis sympathica secondary to brain tumor is rarely as severe as that encountered in our case However, the meningeal reaction associated with spongioblastoma multiforme may be marked because of the rapid growth of these tumors and their tendency to undergo necrosis

Note We wish to express our gratitude to Dr Foster Kennedy, director of the Neurological Division Bellevue Hospital for permission to report this case and to the Neuro-pathological Department, Bellevue Hospital for the use of the photomicrographs of the brain tumor

## SURGEON SAYS CANCER CLINICS HOLD KEY TO CANCER PROBLEM

Cancer of the stomach, which "strikes fear into the hearts of patients," is the most frequent of all malignant growths, according to Owen H Wangensteen, MD, from the Department of Surgery and the Graduate School of the University of Minnesota, at Minneapolis

Writing in the August 2 issue of the Journal of the American Medical Association, Dr Wangensteen says that in the light of present-day knowledge surgery is the only worth-while treatment for patients with gastric cancer, adding that "the most radical surgery with the lowest mortality is the best surgery "

In his article, entitled "The Problem of Gastric Cancer," Dr Wangensteen cites these conclusions

Only six per cent of the patients whose disease is diagnosed as gastric cancer are alive five years later

Only 25 per cent of the patients who have gistric cancer are suitable candidates for a curative type of operation

Gastric cancer is curable, but the problem is to recognize the presence of the disease in time, so that patients will not be denied the real hope that timely and well performed surgical intervention holds out to sufferers from gastric cancer

The death rate for cancer of the stomach is high in almost all countries, and deaths from gastric cancer comprise from 25 to 40 per cent of all cancer deaths

Deaths from cancer in this country rank only next to cardiac disease as the most frequent cause of death, and of the 150,000 annual deaths from cancer in the United States, approximately 40,000 persons die of gastric cancer

New Hampshire, with 30 3 per cent of its people above 45, has an annual cancer mortality rate of 155 4 per 100,000, the highest in the United States

X-rays, discovered in 1895, have since become the most reliable means of diagnosing gastric cancer

Autopsy figures suggest that in men over 20, six per cent of all deaths are due to gastric cancer, and in men between 50 and 70 years, 88 per cent are caused by gastric cancer

In women, 4 3 per cent of deaths at autopsy in patients over 20 years of age are due to gastric cancer, and five per cent of all deaths in women be-

tween 40 and 70 years are caused by this disease.

"The establishment of Cancer Detection Clinics, staffed by specialists, affords the best promise of the early recognition of cancer Women over 40 and men past 50 should report regularly to such clinics

"The solution of a difficult problem such as this demands the following

Members of the medical profession must look at the problem realistically and learn to know all the facts bearing on it

They must constantly enlarge their knowledge of the held by vigorous research and clinical investigation

All available resources must be combined to lend pursuit of the inquiry the greatest promise of solution

The solution of the problem must envisage an interest in the problem as it relates to the present generation as well as to those yet unborn."

## THE AMERICAN COLLEGE OF PHYSICIANS ANNOUNCES ITS ANNUAL SESSION

The American College of Physicians will conduct its 29th Annual Session at San Francisco April 19 to 23, 1948 General headquarters will be at the Civic Auditorium Dr William J Kerr and Dr Ernest H Falconer, both of San Francisco, are the co-chairmen for local arrangements and the program of clinics and panel discussions president of the college, Dr Hugh J Morgan,

professor of medicine at Vanderbilt University School of Medicine, Nashville, Tennessee, is in charge of the program of morning lectures and afternoon general sessions

Secretaries of medical societies are especially asked to note these dates and, in arranging meeting dates of their societies, to avoid conflicts with the College Meeting, for obvious mutual benefits

#### PALLIATIVE SURGERY FOR ADVANCED GASTROINTESTINAL CAR CINOMA IN ELDERLY INDIVIDUALS

WILLIAM SHEINTELD, M.D. Brooklyn, New York

(From the Surgical Sermee of the Coney Island Hospital)

YTENSIVE recoplasms of the stomach or colon are encountered from time to time in elderly patients. The size of the lesion and the patient s age discourage surgical intervention and a laisses fore attitude is often adopted by the physician or Frequently however the poor risk pa tient, after suitable preparation will withstand major surgery of considerable magnitude with amusing resistance and large lesions will prove to be resectable The patient will spend the remaining time of life in relative comfort and freedom from pain and life may be considerably prolonged as well

Extensive scirrhous carcinomas of the stomach and some very large rareinomas of the colon are often free of distant metastases. High subtotal gastrectomy well outside the lesion total gastreetomy, or colectomy will well reward the surgical effort by the palliation effected. In the absence of clinical and x ray evidence of metastases exploration should be performed. Operative confirmation of localization of the legion should be followed by radical operation. The size of the neoplasm and the age of the patient per se should not be deterrent

factora.

Case 1 -H F a white man 75 years old was admitted on October 22 1946 to the surgical service of the Coney Island Hospital The essential facts in the history are as follows There had been increasing constipation for six months. In the six weeks before hospitalisation he had numerous cpisodes of periumbilical pain. The appetite had become impaired but nausen and vomiting were absent. There was considerable weight loss

The physical examination showed an old man with a waxen pallor to his skin and a recent loss of The mucous membranes of the mouth and conjuctivae were pale. A mass of indefinite size which moved with respiration was palpable to the loft of the opigastrium A small umbilical hernia was present. The liver and spleen could not be felt Rectal examination was essentially nega-tive There was no adenopathy in the neck or elsewhere. The cardiovascular and respiratory systems

were normal for his age blood pressure was 130/00 ray studies were made, and a barium onema and chest x-ray were negative. A gustrointestinal series revealed a large tumor mass occupying the stomach from the pylorus to the cardiac region. The pylorus was patent (Fig. 1) The diagnosis

was gastric malignancy.

Laboratory Data.—The electrocardiogram was executially negative. The blood protein was 5.8 Gm per cent albumin was 3.0 Gm globulm was 1.7 Gm. hemoglobin was less than 7.6 Gm red blood count, 2.050 000 and white blood count, 8.200 hematocrit was 20 or cont. blood sugar was 100 mg. hematocrit was 20 per cent, blood sugar was 100 mg.

and the blood urea was 14 mg/100 cc.

The patient was prepared for operation. Several transfusions daily administration of intravenous amigen-dextrose solution and gastric lavage with dilute hydrochloric acid solution were carried out The Lited Acid Company of the blood protein was raised to 6 3 Gm./100 cc



Fra. 1

hemoglobin was raised to 8 Gm., and red blood count was raised to 2,960 000 on the day before operation.

On November 18, 1946 an operation was per formed (W.S.) under fractional spinal anesthesis using pontocaine supplemented with intravenous sodium pentothal sufficient to keep the patient sleeping. Blood transfusion and intravenous glucose and saline were given throughout. With the exception of a few glands along the lesser and greater curva tures no other metastases were noted. The lesion involved the greater portion of the stomach from the fundus down to the pylorus However a small portion of stomach adjacent to the cardia was uninvolved and sufficiently away from the lesion to make high subtotal resection possible

A high subtotal gastrectomy and omentumectomy with anterior gastrojejunostomy was performed The operation was well telerated and postoperative recovery was essentially uneventful. The patient s general condition improved markedly in the postoperative period. His appetite returned and he developed a sense of well-bring. At the time of discharge from the hospital December 10 1046, the hemoglobin was 11.5 Gm. and the red blood count Fig. 2 shows the gross specimen re-The pathologic diagnosis revealed a diffuse carcinoma of the stomach limits plastica type. Fig.

3 is a postoperative gastrointestinal x ray
(arr 2—C C, a white man 58 years old was
admitted on October 9, 1915 to the surgical service
of the Coney Island Hospital. For one year he



Fig 2

had been getting attacks of pain in the right lower quadrant of the abdomen The pain was greatest after meals and associated with nausea There was some relief with passage of flatus For two weeks the stools had been tarry Marked asthenia and dizziness were present for several days before ad-Two years before an appendectomy had been performed

On examining the abdomen a large tender mass occupying the greater part of the right side of the abdomen was palpated It was spherical and roughly the size of a human head There was partial fixation No clinical evidence of metastases was present The patient's general condition was

Laboratory data revealed the blood sugar to be 89 mg/100 cc, urea 15 mg/100 cc, Wassermann was negative, hemoglobin was 74 per cent, there were 3,730,000 red blood cells and 8,600 white blood cells per cu mm., blood pressure was 118/70 barium enema was given on October 14, 1945, and the entire colon filled to the hepatic flexure at which level there was complete obstruction to the barium. There was some distention of the cecum and ascending colon with a suggestion of a mass in this area

The diagnosis was a tumor of the colon Preparations for operation were made and on October 15, 1945, a laparotomy under fractional spinal anesthesia was performed (WS) Numerous adhesions between the peritoneum, the small intestine, and omentum due to the previous appendectomy,

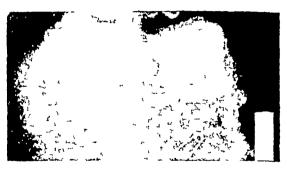


Fig. 3

The cecum and ascending colon were separated were greatly dilated and there was moderate dilatation of the terminal ileum. A huge mass was pal-This was fixed to m There was no pated at the hepatic flexure the lateral-posterior peritoneum gross evidence of metastases Resection of the terminal ileum, right colon, and part of the transverse colon was performed, the peritoneum attached to the mass being taken with it terminal ileum and transverse colon were then brought out in the upper part of the wound as a double barrelled colostomy, a long spur attaching the two segments Recovery was uneventful The spur was subsequently crushed and the colostomy closed extra peritoneally on November 9, 1945 patient was discharged from the hospital on December 1, 1945

The specimen consisted of a large fungating mass occupying the upper portion of the ascending colon and the hepatic flexure. It was about the largest single primary lesion of its kind in the experience of the laboratory. The histologic diagnosis was adenocarcinoma

The patient was seen one year after operation He was in good health and physical examination was essentially negative

## Comment

The scope of surgical endeavor is gradually being extended to include many operative risks previously Total gastrectomy for extensive stomach lesions is now a standardized procedure 1 Likewise, many intestinal lesions are now considered operable which formerly were thought to be too formidable The immediate results in both cases presented are of course gratifying Even if the palliation in the gastric cases is of short duration much is gained over the previous fate of starvation and its attendant nutritional edema Patients over seventy, if in fairly decent general condition, should be given the same opportunity as younger people

#### Reference

1 Lahey, F H and Marshall S F 300 (1944) Ann Surg 119

#### SIMPLE ARITHMETIC

He was only six years old and he had a very sore throat which was being treated with penicillin lozenges

"Doctor, your lozenges hurt my mouth you any that aren't so strong?"

"No sonny, they only make them one strength"
"That's silly," he replied
"They could easily make halfpennycillin lozenges, couldn't they?"—The Lancet, June 28,

#### CONFERENCES ON THERAPY

Departments of Pharmacology and Medicine Cornell University Medical College
and the New York Hospital

THESE are stenographic reports of conferences by the members of the Departments of Pharmacology and of Medicane of Cornell University Medical College and New York Hospital with collaboration of other departments and institutions. The questions and discussions involve participation by members of the staff of the college and hospital students, and visitors. A selected group of these conferences is published in an annual volume Cornell Conferences on Therapy by the Macmillan Company The next Conference will annual volume the December 1 issue.

#### The Management of Peptic Ulcer with Protein Hydrolysates

Dr. Thomas P Almy About two years ago, we had the pleasure of listening to a symposium on peptic ulcer We heard from a medical man who recommended surgery in the management of ulcer We heard from a surgeon who recom mended conservative medical management also heard from a person high in the councils of surgical research who recommended a nutrition program for the treatment of ulcer We carried away from this symposium not only a wealth of understanding of the problem of ulcer which we did not have before, but also a feeling that the approaches to the therapeutic problem were being broadened. The principal speaker this afternoon has described a new concept in the management of peptic ulcer Dr Frank Co Tui, of New York University College of Medi cine will describe his method of treatment of ulcer by hyperalimentation and the use of protein hydrolysates.

DR FRANK Co Tui It was in the course of preparing patients with peptic ulcer for operation, usually gastrio resection that we gave them protein hydrolysates in order to build them up In 4 patients, the pain subsided and a gain in weight took place. The results were so striking that we thought we accidentally had unearthed an important discovery. We then tried it in 30 hospitalized patients who were intractable to the Sippy treatment or to amphoeel with or without antispasmotics. The patients were not on complete bed rest but were allowed to be up and about. We put them on the system of hy peralimentation. This consisted of 0.6 Gm. of nitrogen per KL, in the form of protein hydroly sate in addition to enough carbohydrate to make a total of 50 calories per kg In accordance with this formula, a 70-Kg man received 3 500 calories a day Since the hydrolysate which we used contained 12 per cent nitrogen such a pa tient received approximately 350 Gm. of hy drolysate representing about 1,400 calories The balance of the calories was made up by about 300 Gm of a sugar such as dextrimations. In this series of cases, pain either subsided or markedly dimnished within forty-eight hours. There was prompt gain in weight of as much as a pound a day and there was a feeling of well-being. We also thought there was x my evidence of early healing. Upon discharge, one half of the patients continued dietary precautions and the others did not. We soon learned that the treat ment did not prevent recurrences for of those that followed no subsequent dietary precautions, 4 patients had a recurrence in three months. Therefore this treatment seemed to be no better than other types in proventing recurrences.

We published the early results. The newspaper and radio fraternity who incidentally suffer notoriously from peptic ulcers took up the matter and inflated it into a scientific achievement of the first order Patients queued in front of the laboratory Fortunately I had to go to China, and I thought that was a way out of an embarassing situation but whether it was in San Francisco or Shanghai or Chungking the peptic ulcer patients were always there. I relate this story as a warning against the risk of having one's work overpublicized It did how ever accomplish something. It made available to us a large number of intractable cases of ulcer They seemed to have come out of hiding from physicians and surgeons, hiding in despair They came from all quarters of the globe, and this has given us an opportunity to test the regi men in more than 200 ambulatory patients

In the usual plan, the daily diet consists of protein hydrolysate and dextrimalities dissolved in water the total amount containing about 350 Gm. of hydrolysate and about 500 Gm of the sugar is divided into 8 equal feedings, usually taken at 2-hour intervals, at 8 00 10 00 12 00 2 00 4 00 0 00 8 00 and 10 00 If the pain recurs before the next feeding the intervals are shortened to 1½ or even one hour. These feedings are continued for two weeks after the pain subsides. In 95 per cent of the cases the patient

is free of the pain after the first twenty-four to forty-eight hours. On the fifteenth pain-free day, the patient receives a bland breakfast (an unfried egg, cereal, and toast) followed by the hydrolysate-sugar feedings every two hours. If there has been no pain, the patient receives supper (well-boiled meat, mashed potatoes, toast, and ice cream). If the meals on this day caused no trouble, the diet is extended to three meals on the following day, the sixteenth painfree day. This, together with five hydrolysate-sugar feedings at intervals of two hours, is continued for two months.

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I should like to emphasize that the details of these schedules were arrived at empirically and are subject to variation and improvement. It may be that somewhat smaller amounts of hydrolysates will do. It may be also that the treatment can be terminated in a month or should be extended to as long as six months.

We have used three kinds of hydrolysates with similar results. Some are better than others. A patient unable to tolerate one may be switched to another hydrolysate

To what do we assign the improvement in these cases? We have thought of four possible explanations, none of which is proved the fact that the hydrolysates, being amino acids and peptides, are amphoteric, and neutralize the hydrochloric acid We have shown that, when 50 Gm of the hydrolysate mixture is added to gastric contents with a pH of about 24, the pH rises to 46, and stays that way for about two The administration of a highly nutritious substance may promote the repair of wounds This is also a possible explanation, but very difficult to prove There is some indication that a high blood level of amino acids may cause relaxation of pyloric spasm, since pain may be relieved by their intravenous injection, but the effect of amino acids on gastric and intestinal motility has not been established Then there are the experiments indicating that amino acids may bind pepsin and thereby prevent its action Although this factor has not been studied sufficiently, it remains one of the possible explanations for the mode of action of the hydrolysates These are all merely suggestions They all may be incorrect

From the practical standpoint, the course of peptic ulcer may be divided into three stages first, the stage of acute symptoms, second, the stage in which symptoms have subsided but the ulcer has not healed, third, the stage in which the ulcer is healed. There still remains the problem of recurrence. We are quite sure of the efficacy of the treatment in the first stage, namely, the relief of the symptoms. We do not know how effective it will prove to be in the prevention of

recurrences We know of cases with premonitors symptoms of recurrence in which retreatment for a week checked the symptoms and prevented the recurrence. Obviously, there are many unknown factors promoting the chronicity and recurrence of ulcers. It is possible that a psychosomatic condition or a poor nutrition state may keep them from healing, and that the cycle may be broken by correcting one or the other.

DR ALMY Are there any questions for Dr Co Tin?

DR SEYMOUR H RINZLER The taste of the amino acid digest is a practical problem. How do you overcome it? Most of the materials on the market now have a very bad taste.

DR Co Tui The taste of the hydrolysates is very unpleasant to the normal person, but fortunately, from our point of view, a patient who has had ulcers for five or six years will take anything for relief. The first three days are the most critical ones. After that, patients may even get to like the material. I wish to state, in regard to the taste, that some preparations are better than others.

INTERN Do you make any provisions for vitamins during the period of two or three weeks in which the patients receive only the hydroly-sate-sugar feedings?

DR Co Tui After the first week, we give a full complement of vitamins daily Recently, a patient developed swollen gums on the ninth day of treatment There was a suspicion of scurvy The swelling subsided after vitamin C

DR WALTER MODELL Do all patients gain weight on the hydrolysate-sugar diet?

DR Co Tui Many do, about 50 per cent

DR. HARRY GOLD Would not treatment by the intravenous route serve to distinguish the local from the systemic aspects of the therapy?

DR Co Tui We are able to control the pain by intravenous injection However, it is almost impossible to administer the full caloric and introgen allotment of our hyperalimentation regimen by the intravenous route. You have to give too much fluid

DR GOLD I wonder whether Dr Co Tui has any notion as to what part of the 40 Gm of nitrogen given to an average person in this regimen is really necessary? That is what he happened to find satisfactory in early experiments, and it is understandable that he has continued such doses. Would it be safe to say that 20 Gm of nitrogen might conceivably do just as well, in which case one could give it by intravenous injection?

DR. Co Tul The neutralization of gastric acid with the amount of hydrolysate we use persists for about two hours. With less, it will not last as long. With the amount of feeding

we give, many patients still feel hungry, so that our does cannot be far above the critical one in most cases

Visitor Since Dr Co Tui feeds these patients large amounts of protein hydrolysates with the idea of promoting healing of the ulcer, does be have any data on the blood protein levels before and after treatment?

Dr. Co Tur We gave high protein feeding on a purely empirical basis and not because of an observed effect on the blood protein level all know Charles Lamb's story of the Chinese boy whose house burned down and with it his pig He touched the pig, got his fingers scorched, then reflexly put his fingers in his mouth and found that the taste was good Thereafter. whenever he wanted to have roast pig he burned his house down There is in this an analogy to our treatment We found that 0 6 Gm. of nitrogen did the work and we have continued it We do know, however that in about 20 per cent of the cases, the blood proteins are at the lower limit of normal, about 5.8 Gm per 100 cc

Dn. Modell. In patients with peptic ulcer is there any evidence that there is an inherent difficulty in absorbing or utilizing protein when given in its natural form and not as a hydrolysate?

Dr. Co Tu: We have no indication of that I should, however, like to call attention to an other point, namely, that in patients with pyloric obstruction, the hydrolysate relieves the obstruction We studied 6 patients with partial obstruction, 3 with a complete obstruction through which not even water passed, and lately 2 additional patients with complete pyloric obstruction due to carcinoma of the pylorus these the hydrolysate was able to pass when it was given in small doses, about 0.2 Gm. of nitrogen per Ivg which is approximately what we take normally in a high protein diet. It was an amazing experience. We may be certain that in many cases of pylone obstruction with an organic lesson super added spasm also may play an important role. Hydrolysate feedings provide us with a new management of pylone obstruction I mention this to support the view that the amino acid mixture imposes less of a digestive strain on the gastrointestinal tract than natural food Here are patients in whom even milk would be rejected, but amino acids are allowed to pass

Dr. ALMY The usual diets for ulcer are notor lously low in proteins At a time when we were complaining that the diet of the American prisoner of the Japanese contained only 45 Gm. of protein, I calculated that our standard hourly milk-and-cream feedings provided the ulcer patient with only 35 Gm of protein a day

I wonder what Dr Weintraub has to say about

Dr Co Tui's plan of treatment? We have not yet heard from a radiologist.

DR. SYDNEY WEINTMAUE I was the medleal man proposing surgery for ulcer in the symposium held a few years ago to which Dr Almy referred It was there that Dr Co Tui described his method I have lad no personal experience with it.

Some years ago, I examined the literature and found a remarkable state of affairs. No matter what type of treatment was used whether it was bed rest with the Sippy treatment or ambulatory treatment, or whether it was feeding by tube, the results were about the same. At the end of the first year, there was 80 per cent of cures, if the term cure may be used at the end of the second year it fell to 60 per cent after the third it was 50, after the fourth, 30, and at the fifth year it leveled off at 20 per cent. There was, therefore, a 20 per cent cure in ulcer no matter what method, before the introduction of Dr. Co. Tur's treatment.

The next point I should like to say a few words about is the matter of how to judge a remission or a cure in a case of peptic ulcer First, there are the symptoms, the patient states there is no more pain, he feels fine and he is putting on weight. Then there are the x ray findings, the disappearance of the niche In a great many of these cases which are reported as cured by one or another of these criteria, one finds that they are not cured at all We have had cases in the hospital in which the patient stated he felt well and wanted to go home but the rray showed that the niche had actually grown larger We have operated upon such cases and have found a chronic ulcer stuck to the pancreas. On the other hand, we had 2 cases in whom the niche had practically disappeared, which would make one believe that the patients were cured operation then showed that we had been misled carcinoma had developed in the ulcer

Dr Co Tui has displayed very nice films show ing the reduction in the size of the ulcer should mention that occurs with any kind of treatment We treated large numbers of patients with ulcer at the former Cornell chaic They were mostly ambulant we hospitalized not more than 1 per cent of them. They were all working people and had difficulty in pursuing a rigid diet. In spite of these unfavorable conditions, the niches disappeared in about 95 per cent of them and did so in a very short time. In the average peptic ulcer the niche disappears in about I doubt if it can be accomtwo weeks plished any faster. The rapid subsidence of symptoms and disappearance of the niche after Dr Co Turs treatment seemed to

me much like all of our past experiences with other treatments. I believe that Dr. Co Tui will have something when he can report to us five years later that the curve of recurrences has been materially altered.

Perhaps you will be interested in a story of a single case which we reviewed recently at one of our follow-up conferences I mention it here because in examining the chart, my eye caught the name of Dr Co Tui The patient previously was admitted to this hospital for gastric ulcer, and was discharged improved after eleven days, the treatment to be continued by a private Eight months later, he was readmitted for recurrence of his symptoms history in the interval between these two admissions contained an account of treatments by various doctors, in addition to a course of treatment by Dr Co Tui's method On that regimen, there was diarrhea for three days at the start, the treatment was pursued for fifteen days during which time the patient improved symptomatically and gained eight pounds Then, at the patient's request, three meals a day were added to the regular Co Tui regimen Promptly, the patient began to experience dis-X-ray examination ruled tress with his meals out gallbladder disease and duodenal ulcer patient abandoned this treatment and again consulted various doctors before returning to us for the present admission

There was The x-rays are very interesting the large, broad, base ulcer on the first admission which we reported as a benign ulcer second plate, after the course of treatment by Co Tur's method and others, an ulcer was still The third plate showed marked diminution in the size of the lesion Gastroscopy failed to reveal any lesion Nevertheless, symptoms persisted, and so the patient was operated upon and the area resected Although the lesion appeared to be a benign ulcer on gross examination, the sections showed carcinomatous changes This type of case gives us a good deal of concern, and we are reluctant to temporize with medical treatment because of such experiences I think this person is going to get well, because the resection was made early

I would like to close this discussion by quoting Dr Walter Palmer, of Chicago In a chapter called "The Therapeutic Fallacy," he states as follows "For any chronic disease like peptic ulcer, the course of which is characterized by remissions and exacerbations, the evaluation of therapy is difficult. The cures for ulcer are legion, and most of them will be discarded as their predecessors have been. The annual crop of new cures is due to many factors, one, prevailing methods of treatment are not completely

satisfactory, two, the periodicity of the disease leads to false evaluation of the efficacy of the therapy under consideration, three, the factor of mental suggestion enhanced by the enthusiasm of the physician is extremely important yet difficult to assay, four, and last, the physician and the patient both succumb to the lure of new fads properly advertised "

DR ALM I think we all ought to consider the fact that Dr Co Tur predicted he would have relapses, and was careful to say at least two years ago that the treatment should not be expected to do anything more than produce the first phase of healing

Dr Moore, would you care to comment on the application of these facts to surgical management?

DR SAMUEL W MOORE I think it is perfectly true, as has been brought out in this conference, that in the past we have starved these There has been a tendency to give nothing by mouth, and no protein I share Dr Co Tui's view that these patients should receive protein I also want to reemphasize Dr Weintraub's statement about the periodicity of these Practically all of them can be healed very quickly with medical treatment, but they recur and the patients return to the clinic When we think of peptic ulcers, we should differentiate between ulcers of the duodenum and ulcers of the stomach An ulcer in the duodenum practically never turns into carcinoma, whereas in the case of the stomach, it is a matter of great uncertainty whether it is an ulcer or a carcinoma The doubt often fails to be resolved after repeated gastrointestinal series and gastric an One cannot be certain of it even at operation It is my firm belief, as well as Dr Weintraub's, that, if an ulcer of the stomach fails to heal promptly with medical treatment, an exploratory laparotomy should be performed and if there is anything in the stomach, it should be resected

DR MODELL I should like to ask about the use of Co Tur's diet in bleeding ulcers? Is it continued then, and is the routine the same?

DR Co Tui Yes, it is, and the results are good

DR ALMY I think that the chief objection to feeding in the case of bleeding ulcers is that one might have to operate at any time on such a patient Does not the liquid food overcome that objection to some degree?

DR Co Tui Yes, the stomach is empty within an hour and one-half after a feeding You just omit one feeding and send the patient to the operating room

Dr Weintraub's case is matched by another we had at the French Hospital The patient had

a gastne lesion. We were warned by the x-ray report that it might be a carcinoma. The pa tient felt so well after treatment and gained weight so quickly that both he and his doctor thought he was well He returned in six months with an inoperable carcinoma. It is an important point which I failed to mention in the earlier part of my remarks, namely, the need for differentiating between peptic ulcer of the duodenum and the stomach As to the comparison of the results of our method with those of other methods. I should point out again that we arplied our treatment only to intractable cases cases which failed to respond to other methods Otherwise, our results would have little meaning

VISITOR Is peptic ulcer especially common in countries in which there is nitrogen starvation?

Dr. Co Tui There seems to have been an increase in China. Peptic ulcer was a farly infrequent occurrence among the Clinese During the war mainutrition air raids, and other war wornes played a part in the increase I don't know which one of those factors has brought it about. I am not trying to blame protein deficiency for the production of peptic ulcers, but it is quite possible that protein deficiency prolongs peptic ulcers and prevents them from healing.

DR. KIRST MARTIN Could we ask Dr Co Tui how he selects his cases for this type of treatment?

Dr. Co Tui Our original series were intractable cases. We went to the medical wards where we had patients in bed on a course of Sippy treatment.

When they falled to respond to it after three weeks we took them over Our ambulatory cases usually had a history of from three weeks to three months of ambulatory treatment outside which had failed to control their symptoms, it was then that we took them over

DR. WEINTRAUB What are your results with the marginal ulcers?

Dr. Co To: At first we thought they were very good I don't think they are good at all now

Dr Weintraub mentioned the matter of suggestion in the treatment of peptic ulcer I think it has to be considered but we must not give it too much weight.

The fact that a patient may take one hydrolysate with improvement and another without any, to some extent helps to rule out suggestion as a cause of the response.

DR GOLD I wonder whether Dr Co Tui has had any experience with the yeast hydrolysates There is a material made by Marvin R. Thompson which seems to me to be quite palatable. Dir. Co Tui That reminds me of the subject of preparations The market will be flooded with these products some good and some bad A hydrolyante which is not well prepared can cause more harm than the natural food I would suggest that we confine our work to only those products which have been shown to be efficacious. There is a hydrolysate made from yeast, which is now provided by various companies among them Marvin R. Thompson I have tested it in two cases. One responded well and one did not It is too early to say much about it

There are three products which we are now testing all acceptable and all having good points. These are the casein hydrolysate of E. R. Squibb and Sons the protolysate of Mead Johnson and Company and the lactalbumin distributed by the National Drug Company With these three we have been able to keep our patients fairly happy. In most cases when one is rejected another may be taken without difficulty. I don't know why that is

Dr. McKeen Cattell Are there any side reactions?

Dr. Co Tui Yes there are side reactions The worst one is nausea. Some patients just can't take it. We try to get around that by making the sugar in one solution and the hydrolysate in another The hydrolysate is made up in as small a quantity as possible and chilled They gulp it down and follow it with the dex trimaltose. With that kind of treatment we have been able to reduce the number of reac-Other symptoms may be flatulence distention and diarrhea. Diarrhea is a very prominent one that we control by changing the product. For diarrhea we formerly used amphoiel in one or two tablespoonful doses now we use kaolin or kaopectin in tablespoonful doses That usually controls distribea Flatulence may be controlled by shifting from the dextrimaltose to lactose, and where it cannot be controlled that way we give charcoal with it We have lately observed such reactions as palpitation. flushing and dusziness. They may not be caused by every batch of the product it may be due to histamine or a histaminoid substance

#### Summary

Dr. Gold The discussion this afternoon centered chiefly on the value of a new method for the treatment of peptic ulcer based on the viewpoint that a defect in protein metabolism may be a major factor in promoting peptic ulcer and preventing its healing. The essentials of the method consist in the administration of a high calonic diet representing for the average

adult about 350 Gm of predigested protein in the form of a protein hydrolysate together with approximately 500 Gm of sugar, providing a total of about 3,500 calones daily The utility of this method was discovered accidentally in the course of the preoperative preparation of patients with intractable ulcer The rapid disappearance of symptoms and apparent healing of the ulcer as shown by x-ray led to a more extensive trial Several other advantages of the method have been pointed out, namely, the fact that this diet seems to relax pyloric spasm and is. therefore, applicable to cases with what appears to be complete obstruction, and that it may be used in patients with bleeding ulcer, since the fluid diet, leaving the intestinal tract very quickly, does not interfere with operation should it become necessary The details of the protein hydrolysate-sugar feedings were outlined

The choice of protein hydrolysate preparations seems to be a matter of considerable importance, some being not only more palatable than others, but also more effective from the therapeutic standpoint

The precise manner by which this diet brings about these results has not been established Several theories have been advanced. There is the possibility that it acts in part as an antacid, although there is indication that it may possess other actions as well, both local and systemic. The method is not free of disagreeable reactions,

partly due to the unpleasant taste and local actions of the protein hydrolysates, and partly the result of systemic side-actions

As might have been expected, claims for a new method for the treatment of peptic ulcer would not go unchallenged, and so it has been pointed out that the superiority of this method is fai from proved, that most of the older methods relieve pain just as quickly, and promote the healing of the niche, as shown by x-ray, in much the That hyperalimentation with prosame way tem hydrolysates does not prevent recurrences has already been observed, but whether it will reduce the frequency and numbers of recurrences remains to be seen, and the issue concerning the superiority of this method revolves around Special emphasis was placed on the fact that the striking results with this new method were obtained in patients who had failed to respond to the older methods of treatment

The discussion brought out several additional points of interest, which one cannot afford to forget, namely, the fact that symptoms of ulcer may subside while the ulcer niche continues to enlarge, and, conversely, that the size of the niche may diminish, which suggests healing while the symptoms persist. The desirability of surgical exploration in the latter cases was emphasized, especially in cases with gastric ulcer, since in these there is always the danger of carcinomatous degeneration.

#### ANNOUNCEMENT OF NEW OFFICERS

The American Laryngological, Rhinological and Otological Society, Inc., announces the following officers for the year 1947 to 1948 Dr. Lyman G. Richards, Brookline, Massachusetts, president, Dr. John J. Shea, Memphis, Tennessee, president-elect, Dr. Kenneth M. Day, Pittsburgh, Pennsylvania, treasurer, Dr. Theodore E. Walsh, St. Louis, Missouri, editor, Dr. Raymond H. Marcotte, Nashua, New Hampshire, fellowship committee, Dr. C. Stewart Nash, Rochester, New York, secretary. The following will be vice-presidents. Eastern Section, Dr. J. Winston Fowlkes New York City, Southern Section, Dr. William A. Wagner, New Orleans, Louisiana, Middle Section, Dr. Hugh G. Beatty, Columbus, Ohio, and the Western Section, Dr. Meade Mohun, San Mateo, California.

The members of the Council are Class A, Dr James G Dwyer, New York City, Dr H Marshall Taylor, Jacksonville, Florida, and Dr Walter H Theobald, Chicago, Illinois Class B, Dr Albert C Furstenberg, Ann Arbor, Michigan, Dr Rea E Ashley, San Francisco, California, and Dr LeRoy A Schall, Boston, Massachusetts Class C, Dr Harry W Lyman, St Louis, Missouri, Dr Francis E LeJeune, New Orleans, Louisiana, and Dr Henry B Orton, Newark, New Jersey

The coming Section Meetings will be held as follows Eastern Section, January 16, 1948, New York City, Middle Section, January 19, 1948, Columbus, Ohio, Southern Section, January 23, 1948, New Orleans, Louisiana, and the Western Section, January 31 to February 1, San Francisco

uary 31 to February 1, San Francisco
The midwinter Council Meeting will be held in
New York City on January 17, 1948

Arrangements have been made to hold the Annual Meeting at Chalfonte-Haddon Hall in Atlantic City on April 7, 8, and 9, 1948

City on April 7, 8, and 9, 1948

The American Otological Society and the American Laryngological Association are planning to hold their meetings at Old Homestead, Virginia, the former on April 12 and 13, 1948, the latter on April 14 and 15, 1948

#### House of Delegates

## Minutes of the Annual Meeting

May 5 to 7, 1947

[Continued from page 2030, September 15 issue]

[Sections 69-94 appear in this issue. For Subject Index see August 15 issue, page 1799]

#### Morning Session Tuesday, May 6, 1947

Section 69 (See 45)

Report of the Reference Committee on Report of Council—Part X. Qualifying and Rating Physicians Under the Workmen's Compensation Law

DR. F. W. HOLCOMB. Ulster. The next is a resolution introduced by Dr. William J. Orr on qualifying and rating physicians under the Workmen s. Compensation Law, and which reads.

"WHEREAS the proper rating and authorization of physicians is vitally essential to the effective accomplishment of the purposes of the Workmen s Compensation Law particularly the provision of

the highest quality care for injured workers, and "WHENEAS, the County Medical Societies of this State have performed a notable job in assisting the Chairman of the Workmen a Compensation Board to properly rate and authorize physiclans to render medical care to persons entitled to the benefits of the Workmen's Compensation

Law, and
Wheneas, the 1947 State Legislature enacted
the Condon bill which empowers the Chairman of the Workmen's Compensation Board to review and revise physicians' compensation ratings and

WHEREAS the Medical Society of the State of New York believes that the County Medical Societies, because of their specialized knowledge, familiarity with local conditions and with the actual qualifications of physicians are best equipped to determine the character of medical care physicians are qualified to render, therefore be it

Resolved, that the Medical Society of the State of New York at this duly convened session of its House of Delegates, recommend to the Chairman of the Workmen a Compensation Board that revi-sions of ratings be made by the County Medical Societies and the Chairman of the Workmen's Compensation Board in accordance with the

qualifying standards heretofore formulated by the County Medical Societies and be it further Resolved that a copy of this resolution be transmitted by the Secretary of the Medical Society of the State of New York to the Chairman of the Workmen s Compensation Board.

Under the Act (Condon, 1708) this law provides that a change of rating shall be made only on recom-mendation of the Medical Society or of the Medical Practice Committee On such advisory recommen-dation, the Chairman of the Workmen's Compensation Board may review or after reasonable investigation may revise, the rating of said physician according to the character of medical care which he is actually qualified to render

If a physician is dissatisfied he may apply to the Medical Appeal Unit of the Department of Labor We feel that a physician should be entitled to a

hearing before a change in his rating is made. Qualifications for recommending ratings are adopted by the County Medical Societies them-

colvea. Your Reference Committee feels that under the

revised law no hearing is afforded before change of rating is made either by the Medical Society or the Medical Practice Committee Such hearing should be afforded by either or both before any change is made.

This resolution does not properly reflect the law a. amended We approve this however in principle in the matter of authorization or recommending rating through the action of the County Societies. I move the approval of the action of the Reference

Committee in this matter

The motion was seconded, and as there was no discussion, it was put to a vote and was unanimously carried

Section 70 (See 89)

Report of Reference Committee on Report of Coun Activities of the Medical Practice cli—Part X Committee

DR. F. W. HOLCOMB Ulater The next is a resolution introduced by Dr. J. F. Painton, of Eric

County concerning the activities of the Medical Practice Committee and reading
"Wiffenbas, the Medical Practice Committee of Greater New York functioning as a statewide agency of the Workmen & Compensation Law research ceives applications for, and recommends rating and rerating of physicians outside Greater New

York, and
WHEREAS, the Medical Practice Committee of
Creater New York has established standards for qualifying physicians throughout the state, and

WHEREAS, the Medical Practice Committee of Greater New York receives applications for and recommends the licensing of Workmen a Compensation Medical Bureaus outside Greater New

JOHN AND THE ASSESSMENT OF THE MEDICAL PROCESS OF THE MEDICAL PROCES be it

Resolved, that the counsel of the Medical Society of the State of New York proceed legally to reetrain the Modical Practice Committee activities as a statewide agency of the Workmen a Compensation Law

This resolution undoubtedly ments consideration as a complaint against an alleged existing practice of However, it does not offer a qualifying physicians constructive alternative procedure, such as the abolition of the Medical Practice Committee, and to restrain the present Committee's activities would result in confusion

Under the present law, the component county societies in all counties with a population of less than 1,000,000 have jurisdiction in recommending physicians for authorization to practice under the Workmen's Compensation Law They have their own standards of qualification, as the Medical Practice Committee has no jurisdiction in these counties

Therefore, your Reference Committee recommends disapproval of this resolution in its present

form, and I so move

The motion was seconded, and as there was no discussion, it was put to a vote and was unanimously carried

Section 71 (See 48)

Report of Reference Committee on Report of Coun-Increase of Workmen's Compensation cıl—Part X Fees

Dr. F W HOLCOMB. Ulster The fourth resolution is the one introduced by Dr A F Gaffney, of Oneida, and concerns an increase of the workmen's compensation fees

"Whereas, the cost of medical practice has markedly increased since the present fee schedule of the Workmen's Compensation Department was revised, and

"WHEREAS, the fees of private practice in the County of Oneida have increased due to the rise

of the cost of medical practice, be it

"Resolved, that the delegates to the State Convention from Oneida County be instructed to present to the House of Delegates of the State Society. a resolution asking for an increase in the workmen's compensation fee schedule "

This has already been accomplished, and the resolution is approved in principle. I so move

The motion was seconded, and as there was no discussion, it was put to a vote and was unanimously carried

DR ABRAHAM KOPLOWITZ I thought you were going to report on Dr Dattelbaum's report at this

Dr Holcomb No, Dr Dattelbaum's report will be brought in under the whole report of the Reference Committee of the Report of the Council, Part X These were just various resolutions that were referred to us and on which we are ready to report at this time

Speaker Andresen Dr Dattelbaum's report will be reported on later?

DR HOLCOMB

Section 72 (See 7)

Report of the Reference Committee on Report of the Planning Committee for Medical Policies

Dr Thomas M D'Angelo, Queens Your Refcrence Committee has carefully reviewed the report of the Planning Committee for Medical Policies and has been amazed at the amount of work that has come before this Committee during the past year Such a Committee is one whose organization should be more or less the same from year to year and your Reference Committee notes that this plan has been tollowed

The report of your Reference Committee will be as brief as possible, and will touch only on those portions of the report which require action from this It is manifestly impossible for your Reference Committee to completely grasp in a few hours what has taken many meetings and many hours of work on the part of the Planning Committee

The Reference Committee is in full accord with the reorganization of committees where there is overlapping and approves the changes suggested and the renaming of committees to conform with similar ones

in the American Medical Association

I move the adoption of this portion of the report The motion was seconded, and as there was no discussion, it was put to a vote and was unanimously carried

Dr D'Angelo The Reference Committee also approves the recommendation to appoint an advisory committee of specialists within their respective sections to assist the Executive Officer, Dr Robert Hannon, to advise or aid him in matters of legislation and other problems affecting each respective specialty

I move the adoption of this portion of the report The motion was seconded, and as there was no discussion, it was put to a vote and was unanimously carried

Your Reference Committee D'Angelo approves the arrangement of honoraria paid by the New York State Department of Health to speakers participating in joint postgraduate medical educational programs sponsored by their Society and the Health Department of the State of New York.

I move the adoption of this portion of the report The motion was seconded, and as there was no discussion, it was put to a vote and was unanimously carried

The Planning Committee has Dr D'Angelo undertaken an extensive study of hospital facilities and requirements for New York State, especially in relation to the method of distributing this hospital The Federal Governcare throughout the state ment has made available certain sums of money for medical care and New York State is ready to meet the necessary requirements to get this money Your Reference Committee has studied very carefully this section of the report and is of the opinion that any steps taken at this time will set a pattern for the future medical care and practice in the State

The State will establish a number of County General Hospitals in various sections of this State These hospitals are to be served by the local doctors of the community through medical boards are to be connected also with teaching centers for the continuous postgraduate instruction of the medical staff and the physicians of the community This is a staff and the physicians of the community praiseworthy object and one which should be helped in every way, but Organized Medicine should watch this very carefully lest the control and management of these hospitals be taken over by teaching institutions Fortunately, one experiment is now going on, one in the Rochester area and one is projected in Schoharie County The results of these experiments will be watched very carefully by the Planning

The Reference Committee endorses, first, the development of county health units, and, second, the requirement that where state-supported county hospitals exist or may be planned in the future they contain a county health department where such facilities are now inadequate

I move the adoption of that portion of the report

DR. HARRY E. REYNOLDS Section Delegate

second the motion

Speaker Andresen It has been regularly moved and seconded that that portion of the report be adopted Is there any discussion?

DR. THOMAS A McGOLDRICK (Past President) Before putting that motion to a vote, may I ask to have a point cleared up? That part of the resolution now offered only includes the part that has just been repeated at this moment, and not the entire part read, is that right?

DR. D ANGELO It includes only this portion of

the report that was read.

DR. McGoldrick Does it include the entire part that you read or just the part you repeated when

you moved the adoption?

Your Reference Committee en-Dr. D Angelo dorses first the development of county health units and, second, the requirement that where statesupported county hospitals exist or may be planned in the future they contain a county health department where such facilities are now inadequate part before that was explanator

DR. McGoldrick That is what I thought but I

DR. MCGOLDBIGA wanted to make sure of it

ANDRESEN The endorsement is of

DR. D ANGELO Dr McGoldrick's point would be pertinent in a motion that I intend to make later on the adoption of the report as a whole, so I don t see why it could not be discussed now and cleared up

DR. McGoldrick In what Dr D Angelo says was the explanation and which was read as part of the report it was stated as I heard it that these hospitals to be erected are to be staffed through the modical board. Do you include that in your resolution?

SPEAKER ANDRESEN That would be included in any event in the motion to adopt the report as a whole. Dr. D ANGELO That is not included in the

resolution. Dr. McGoldrick But that was in the explana-

tion? Dr. D Angelo That was in my previous explanation

DR. McGOLDRICK Very well

The question was called, and the motion was put to a vote and was unanimously carried

Dr. D ANGELO Your Reference Committee finds that the Planning Committee has already begun the study of the United Mine Workers Welfare and Retirement, and Health and Hospital Funds. though this does not affect the physicians in New York, a pattern may be set for similar action by other labor organizations in this state. Some definite plan should be prepared to cope with this

rapidly developing situation
The Tait-Smith Ball Donnell Bill (S-545) and the Fulbright-Taft Bill (8-140), and the Aiken Bill (8-712) were carefully studied by the Planning Committee An analysis of these bills should be read by every member of the Society We shall not take the time to analyze these bills here.

The study of Group Practice necessarily became an important part of the agenda of the Planning Committee, and that committee reaffirms the set of principles for group practice approved by the Co-ordinating Council of the five County Medical So-cioties of New York City as of November 1, 1945

The committee notes the enactment into law of bills to permit physicians to practice in partnership and to pool fees, and to allow under the provisions of IN-O of the Insurance Law the employment of physicians by nonprofit medical indemnity and hospital service corporations to treat persons in-sured by them. The State Society opposed this legislation because we felt that the bills were loosely drawn and opened up avenues for flagrant violations of medical othics and that they would be contrary to the best interests of the public. Your Reference Committee endorses the recommendation of the Planning Committee that this House of Delegates authorize the Council to have drafted suitable legislation to cover the matter of partnerships and group practice within the principles already approved by the State Society, and that in the drafting of this proposed legislation other interested agencies be con sulted and their aid and cooperation solicited

I move the adoption of this portion of the report.

DR. EDWARD C VEPROVSKY Queens I second

the motion

Speaker Andresen It has been regularly moved and seconded that this portion of the report be adopted Is there any discussion?

DR. HARRY ARANOW (Councilor) Just for in formation, just what other agencies are contem plated? I think we ought to know something about that

DR. D ANGELO Dr Kenney can explain that por tion.

DR. J STANLET KENNEY (Councilor) We did not have in mind any particular agency or agencies but we thought in the framing of such a bill it might be necessary to consult with proper types of organiza itions in order that they might give us some aid in gotting such a bill passed We did not have in mind any specific one. That will have to be worked out later I think.

DR. D ANGELO In reading that over I got the same impression as Dr Kenney has explained, that the Committee would like to go out and got any necessary aid that it could. I think that would be the explanation of it and that is all I can say about it

Speaker Andresen Is there any further discussion?

The question was called, and the motion was put to a vote and was unanimously carried

Dr. D Angrio Your Reference Committee feels that the members of the State Society owe a vote of thanks to the members of the Planning Committee for their tireless efforts in behalf of the Society

I move the adoption of the report as a whole. DR. EDWARD C VEPROVSKY Queens I second the motion.

SPEAKER ANDRESEN It has been regularly moved and seconded that we adopt the report as a whole. Is there any discussion?

DR. J STANLEY KENNEY (Councilor) In the writing of the report I failed to include a request that the House of Delegates authorize the continuation of this Committee for another year seems to me that the work under study is continuing work, and will require supervision and co-operation with the state authorities therefore, I believe it is to the best interests of this Society to keep this Committee alive another year I would like this Committee alive another year I would like to amend the motion to add that, that the House extend the life of this Committee for another year

DR. D ANGELO We will accept that as a portion of our report, to continue the life of the Planning Committee for Medical Policies for another year an I I therefore move the endorsement of the report as a whole with that added as well as our commendation

of this Committee.

Dr Veprovsky I will include that in my second
There being no discussion, the motion was
put to a vote, and was unanimously carried

Section 73

Report of Reference Committee on Constitution and Bylaws Proposed Amendment to Charter Is, Section 1, of the Bylaws

DR PETER J DI NATALE, Cenesee Your Reference Committee on Amendments to the Constitution and Bylaws begs to submit the following re-

port

On the proposed amendment to Chapter IX, Section 1, of the Bylaws, introduced by Dr Stephen H Curtis, delegate of the Section on Pathology and Clinical Pathology, in order to avoid possible confusion later, may I read Chapter IX, Section 1, up to the present suggested amendment

"Chapter IX, Expenses, Section 1 Allowances for expenses incurred in the actual performance of official duties by officers, members of the Council, the Board of Trustees, of the Board of Censors, and committees, and delegates to the American Medical Association shall be made in conformity with the following conditions. The President shall be allowed a per diem and expenses when engaged upon official business. All other officers shall be allowed traveling expenses when engaged upon official business. Members of the Council, of the Board of Trustees, and the Board of Censors, shall be allowed traveling expenses. Members of Committees of the Council, and all special committees of the Society, shall be allowed traveling expenses. Presidents of the District Branches sitting in the House of Delegates shall be allowed necessary expenses."

The proposed amendment would add, following the words "Presidents of the District Branches," these words

"and delegates from the scientific sessions," so that the sentence would then read in full

"Presidents of the District Branches and Delegates from the scientific sections sitting in the House of Delegates shall be allowed reasonable expenses"

Your Reference Committee, after considerable discussion, is of the unanimous opinion that this

amendment be disapproved, because

(1) This will be an added expense to the State Society at a time when the State Society is contemplating asking for increased dues to meet current and expected increases in operating expenses

(2) We feel that should the State Society assume this additional item of expense, other group or groups will also desire that their expenses be paid

(3) The delegates from the Scientific Sections were added to our Constitution and Bylaws in order to more closely conform to the House of Delegates of the American Medical Association. We are informed that the American Medical Association has no provision for payment of necessary expenses of the Section Delegates. We do not wish to set up a bad precedent for the American Medical Association.

I move the adoption of this portion of the report DR JAMES R. REULING (Treasurer) I second the motion.

Speaker Andresen It has been regularly moved and seconded that this portion of the report, which disapproves of the proposed amendment introduced last year, be adopted Is there any discussion?

DR STEPHEN H CURTIS (District Delegate) I submitted this proposal a year ago at the request of the delegates from the Scientific Sections There being no funds available, they felt that a reasonable expense should be allowed them District Presidents are allowed an expense account as well as other committee members, however, the amount of money involved is small compared with some of the other expenses, so I can see no reason why the adoption of that change should not be made

Speaker Andresen Is there any other discussion?

DR REULING These small additions very frequently grow up to be big items. Dr Curtis says that the Presidents of the District Branches are allowed reasonable expenses. Well, the Presidents of the District Branches are really junior officers of the State Society, and it is for that reason that their expenses are paid. They are in no way comparable in my opinion to the delegates from any County or the delegates from any Section. I believe that this would be an opening wedge, if adopted, therefore, this House of Delegates should approve the Committee's report to disapprove the proposed amendment.

PRESIDENT BAUER Just a point of parliamentary procedure, I am not arguing on the motion Ordinarily we consider the Committee's report and adopt or reject that, but this is an amendment to the Constitution and Bylaws, and we should consider that and not the Committee's report I think the motion should be on the adoption of the amendment and not on the adoption of the Committee's report, merely to make it in parliamentary form

SPEAKER ANDRESEN Thank you The Reference Committee then recommends that the amendment not be adopted The vote will be on the amendment, and it requires a two-thirds vote to pass an

amendment

Dr. Di Natale To supplement Dr Reuling's statement, the Presidents of the District Branches are really your Board of Censors, with the President of the State Society and the Secretary of the State Society, so they really are officers of the State Society.

DR CURTIS May I propose that this be put over

for another year?

SPEAKER ANDRESEN Laid on the table?

DR CURTIS Yes

DR JAMES F ROONEY (Trustee) I rise to second Dr Curtis' motion

Dr. Alfred M Hellman, New York Can that be done now?

DR DI NATALE I don't think so

Speaker Andresen There is a question about it in my mind

DR ROONE: And I would state that without question that matter can be laid upon the table. The Constitution and Bylaws provide simply that a proposed amendment cannot be voted upon without due notice having been given at one annual meeting, and the amendment shall be taken up for consideration at a succeeding meeting from that at which it is proposed. Actually, in effect, what Dr Curtis is proposing is that this be laid on the table for this meeting, and giving notice to the House of Delegates that he intends to introduce it at this meeting again to be acted upon at a succeeding meeting.

Dr. Di Natale I believe that is incorrect. This was introduced last year at the House of Delegates

by Dr Curtis

DR. ROONEY That is right

DR. Dr NATALE It was published in the annual

reports about a month or so ago

DR. ROONEY Yes but if I could read the section relative to amending the Bylaws you would see there m no provision in it that it cannot be laid over for still another year The only provision is that it cannot be acted on without due notice, and such due notice is to be given at the preceding annual meeting.

SPEAKER ANDRESEN But there is no provision for its being laid on the table either as far as I can

Dr. Rooney You are quite correct. There is no provision against it.

SPEAKER ANDRESEN I will put the motion to lay this on the table

The motion to table was put to a vote and

was lost. SPEAKER ANDRESEN Now we come to the amend ment itself. We are voting now on the amendment to the Bylaws which the Reference Committee recommended be not adopted This requires a two-thirds vote to carry the amendment

Dr. Erra A. Wolff Queens Willavote of 'Ave

now approve or disapprove the amendment?

SPEAKER ANDRESEN A vote of "Aye approves the amendment, which has been disapproved by the Reference Committee. Is that clear?

We are not ready CHORUS

Dr. Di NATALE I think you misstated it. You

said it disapproves the amendment.

SPEAKER INDRESEN An affirmative vote approves the amondment, which the Reference Committee recommended be disapproved. We are voting now on the amendment itself MEMBER An affirmative vote would support the

recommendation of the Committee?

SPEAKER ANDRESEN No an affirmative vote will pass the amendment.

CHORUS No.

DR. JAMES R. REULING That is right. We are voting on the amendment itself not on the recommendation of the Reference Committee.

SPEAKER ANDRESSN Correct. An affirmative vote will pass the amendment. All in favor of passing this amendment say Aye now those op-posed, 'Nay I think it is safe to say it is more

than a two-thirds vote disapproving the amend-ment. The amendment is lost.

DR. ALFRED M HELLMAN, New York. I afraid we may have a little trouble at a later date think voting on this report has nothing to do with voting on the amendment That will have to come up under that special business of voting on amend ments.

PRESIDENT BAUER That is just what we did. The vote just now was on the amendment,

SPEAKER ANDRESEN That is right.

Those who voted "Aye PRESIDENT BAUER voted in favor of the proposed amendment.

DR. HELLMAN But it was out of order not to

vote on the Committee report now It was not in order to vote on the amendment.

PRESIDENT BAUER Why not?

SFEAKER ANDRESEN This amendment was introduced last year and legally should come up today for adoption or relection and it has been disapproved, so the amendment is lost.

DR. HELLIAM Point of information, isn t there

a provision made on our program where we discuss proposed amendments to the Constitution and By

laws specifically?

SPEAKER ANDRESEN NO Dr. Di NATALE May I proceed? Сновив: Yes.

Section 74

Report of Reference Committee on Constitution and Bylaws Proposed Amendments to Article II of Constitution and Chapter I of the Bylaws

DR. PETER J DI NATALE, Genesee On the proposed amendment introduced by Dr. Samuel B. Burk, New York, Amend Article II of the Constitution by adding after the word Honorary the fol (d) Associate and place the period after the word Associate.

"Amend the Bylaws by adding a section to be known as Section 8 at the end of Chapter I of the

By laws as follows

' bection 8 The Associate Members of this Society shall be graduate physicians who are affiliated fulltime with the Veterans Administration or are serving on permanent appointments in the regular Army or Navy Medical Corps who are stationed temporarily or indefinitely within the State of New York and who shall have been ad mitted to a corresponding form of Associate Membership, without vote in a component Associate Members of county medical society the Medical Society of the State of New York shall pay the regular assessments of the State Society in the same manner as active members. The specific requirements for admission as an Associate Member shall be established by each of the component medical societies.

Your Reference Committee feels that members of the uniformed services, of the Veterans Administra-tion, and of the United States Public Health Service or any other federal services relating to health activities are always welcome to the scientific sessions of our state and local medical societies.

We believe that at present each county medical society may amend their own constitution and by laws allowing these societies to have any type of membership they desire, so long as it is submitted to the Council for approval before it becomes effective.

This amendment states that these associate mem bers of the Medical Society of the State of New York shall pay the regular assessment of the State Society in the same manner as active members.

Your Committee feels that if you assess these associate members like active members you should give these associate members the same privileges that active members have, namely

(1) Receive the JOURNAL
(2) Act as delegates
(3) Malpractice insurance

Malpractice insurance and defense Receive the Directory

Vote and hold either elected or appointed

offices

(6) Aid from the workmen's compensation bureau, etc.

Your Reference Committee, after full discussion, is of the unanimous opinion that such an amend ment to the State Society's Constitution and Bylaws is not needed nor necessary therefore, we recom-mend disapproval of this amendment. I move that mend disapproval of this amendment the amendment be not approved

SECRETARY ANDERTON I second the motion.

SPEAKER ANDRESEN We are in the same situa We have an amendment tion as we were in before. before the House and our Reference Committee has recommended that it be not adopted The amend ment is to create Associate Membership with cor

tain privileges. Is there any discussion?

Dr. Samuzi B Burk, New York. When this amendment to the Constitution and Bylaws was originally brought to the House it was at the request of the New York County Medical Society to me have had occasion to serve in both wars and was stationed in different places where the medical men connected with the armed forces were given little, if any, notice of events that went on in the different We were not told about the varimedical societies At that time it would have been very ous activities helpful for those who were in the armed forces to participate in what Organized Medicine had to offer, whether it was to go to meetings, to meet the local men and exchange ideas, or to participate in scientific procedures

I have had occasion to discuss this proposed amendment with the Chairman who has made his recommendations to you, and in view of what he tells me that this provision can be cared for by each county medical society I believe that the action taken should be to negate this amendment of mine

(Applause)

SPEAKER ANDRESEN All those in favor of adopting the amendment which is against the recommendation of our Reference Committee will say "Aye", contrary "No" The amendment is lost

(See 42) Section 75

Report of Reference Committee on Constitution and Bylaws Proposed Amendment to Chapter I of Bylaws

DR. PETER J DI NATALE, Genesie On the resolution that was referred to our Committee on Amendments to Constitution and Bylaws as presented by Dr Homer J Knickerbocker, of Ontario County, its substance is about the same as the previous amendment, however, I will read the change that he proposed so you may follow our recommendation

"Whereas, the present Bylaws of the Medical Society of the State of New York make no mention of Associate Membership, therefore be it

"Resolved, that Chapter I of the Bylaws entitled 'Membership' shall have added thereto a new section to be known as Section 8, to read as follows

"'Section 8 Constituent County Medical Societies may elect Associate Members from among the personnel of U S Government facilities located within their jurisdiction by following the same routine as prescribed for the election to Active Membership, except that New York State Registration may not be deemed essential

"'Associate Members shall be exempt from payment of State Medical Society assessments They shall be accorded all the privileges of Active Membership except voting, holding elective office, or being eligible to malpractice defense by counsel of the Medical Society of the State of New York."

Your Reference Committee feels that this amendment is not needed, nor necessary in order to fill out our State Society's Constitution and Bylaws recommend that this be not adopted

I am told by our Secre-SPEAKER ANDRESEN tary that this was only introduced at this meeting of

the House

a. ~.3

Dr. Knickerbocker Yes, but it was offered as a substitute or an amendment to the previous recommended amendment.

After having listened to Dr Burk, and the explanation given by the Chairman of the Reference Com-

mittee, I would like to withdraw this

SPEAKER ANDRESEN I was wondering what the procedure would be now that the amendment was

I don't know how we can act on this at this session of the House However, the amendment has been withdrawn, and we also declare it could not be acted upon thus year

Dr. DI NATALE Dr Knickerbocker has with-

drannit

Speaker Andresen Very well, proceed.

(Sec 41) Section 76

Report of Reference Committee on Constitution and Bylaws Amendment to Article II of Constitution

DR PETER J DI NATALE, Genesce Would Dr Knickerbocker also like to withdraw his proposed amendment to Article II of the Constitution, which covers the same subject of Associate Membership, and which was introduced under similar circumstances?

DR. HOMER J KNICKERBOCKER, Onlario would

DR DR DI NATALE Thank you! That makes it easy, and I will not have to give the report on that, which was also of disapproval

SPEAKER ANDRESEN It has been withdrawn

Thank you, Dr Di Natale!

It has been suggested, as the delegates are becoming a little restless, that perhaps they would like a tte recess (Applause)
There was a five-minute recess at this five-minute recess

point

SPEAKER ANDRESEN Will you please come to order, gentlemen?

We will have the introduction of resolutions, before we get back to the Reference Committee reports Are there any resolutions?

Section 77 (See 25, 115) Specialty Boards

DR FRANK LAGATTUTA, Bronx I would like to have the permission of the House to withdraw my original resolution on specialty boards, and if that is given I will substitute an alternate resolution

SPEAKER ANDRESEN We will first have to have the permission of the House to withdraw your original

nal resolution

Dr. Ezra A Wolff, Queens I move that such

permission be granted

The motion was seconded, and as there was no discussion, it was put to a vote, and was unani mously carried

Speaker Andresen The original resolution as presented by you has been withdrawn, by consent of

the House

Dr. LaGattuta Non I would like to introduce an alternate resolution

"WHEREAS, it is the policy and aim of the American Medical Association to foster affiliations of all physicians with a hospital in order that they might continue their education and increase their efficiency, and

"WHEREAS, interference in doctor-hospital relationship is influenced by the indirect action of the

various specialty boards, and

"WHEREAS, on account of the numerous complaints from returning veterans being unable to qualify for the boards on account of a lack of available and acceptable residencies, and

"WHEREAS, this condition is prevalent through-

out the country, therefore be it "Resolved, that the delegates of the Medical Society of the State of New York be directed to

memorialize the House of Delegates of the American Medical Association at its forthcoming June meeting in Atlantic City that the Board of Trustees be requested to appoint a committee for the purpose of investigating the Hospital Specialty Board relationship and to take whatever means are necessary to correct the situation

SPEAKER ANDRESEN Referred to the Reference Committee on New Business A, of which Dr Leo F Simpson is Chairman

Section 78 (See 72,120)

Group Practice and Partnership

DR. AARON KOTTLER, Kings Mr Speaker the Comitia Minora of the Lings County Medical Society passed this resolution

WHEREAS, the New York State Legislature enacted Senate Introductory 740 Printing 2142 in the 1947 Legislature, which is now a chapter of the laws of 1947 of the State of New York, and

WHEREAS, said law amends the Education Law in relation to the practice of medicine by physicians as partners and permits the pooling of fees and monies for medical services by the members of the partnership or group and employees of such

partnerships or groups and
WHENEAS said bill does not \*pecify or limit the number of partnerships or groups to which an in

dividual physician may belong and

WHEREAS, under the present bill, a physician might be a member of more than one group and use this as a subterfuge for fee-splitting and also create a situation where said member of more than one partnership might be tempted to render services for less than the agreed fee among the group and Whereas, said bill permits a division of the

fees with an employee who does not necessarily have to be a physician under the terms of the bill

therefore be it

Resolved, that we request that legislation be introduced in the 1948 session of the New York State Legislature amending the recently enacted law concerning group practice or partnership and incorporating therein provisions or amendments to correct the foregoing objections

SPEAKER ANDRESEN Referred to Reference Committee on New Business C of which Dr Theo-

dore J Curphey is Chairman
DR THOMAS J D ANGELO Queens

That has aiready been taken up by my committee and we made the recommendation on that matter before. We recommended just what Dr Lottler has in that resolution

SPEAKER ANDRESEN Do you want me to refer

the to your Committee instead?

DR. D ANGELO We have already acted on it SPEAKER ANDRESEN We will refer that to the Reference Committee on the Report for the Planning Committee for Medical Policies

Section 79 (See 124)

Workmen's Compensation-Medical Practice Com mittee

DR. AARON KOTTLER, Kings I wish to introduce another resolution as follows

'WHEREAS, in the years 1935 to 1944 under the laws of the State of New York, the power to rate physicians who were to treat Workmen's Com pensation cases in the City of New York and to investigate all charges of misconduct in the treat

ment of Workmen's Compensation cases and to arbitrate all claims where there is a difference of opinion as to the fee to be paid by the insurance company to the physician was assigned to the County Medical Society, and Whereas in 1944 laws were passed taking

these powers away from the County Medical Societies in the four largest counties in Greater

New York and

'Whereas, the County Medical Societies had conscientiously attempted to follow the provision of the Workmen s Compensation Act during the years from 1935 to 1944 and

Wheneas there were practically no com-plaints concerning the rating of physicians or arbitration by either these physicians the insur-ance carriers, or the State Department of Labor therefore beit

'Resolved, that we request that legislation be introduced in the New York State Legislature in the 1948 session to restore to the County Medical Societies of Greater New York the powers which they had under the compensation laws of 1935

Speaker Andreson Referred to the Reference Committee on Report of the Council, Part Workmen a Compensation

Section 80 (See 101)

X-Ray Diagnosis

Dr. Aaron Kottler, Aings I have a thresolution to present regarding X-ray Diagnosis I have a third

"Whereas, a bill to amend Section 1250 of the Education Law of the State of New York in relation to practice x-ray diagnosis and treatment, and treatment by radium was introduced in the 1947 legislature, which bill was not passed therefore be it

Resolved that the Medical Society of the State of New York request that a bill be introduced in the New York State Legislature in 1948 as fol-

A ray diagnosis means that method of medical practice in which demonstration and exammation of the normal and abnormal structures parts or function of the human body are made by use of x rays and any person who holds him-self out to diagnose or able to make or makes any interpretation or explanation by word of mouth writing or otherwise, of the meaning of a fluorescopic or registered shadow or shadows of any part of the human body made by the use of x rays, and also the use of x rays or radium for the treatment of any human allment, shall be deemed to be engaged in the practice of medicine within the meaning of this article and Section 1262 as follows The provision of this article shall be deemed to prohibit the practice of x ray diagnosis, x ray therapy or radium therapy as defined in subdivision 7A of Section therapy 1250 of this chapter by any person other than a person licensed as a physician a dentist, an osteopath or a podiatrist.

Be it further

Resolved, that the Medical Society of the State of New York actively work for the passage of such a bill in the Legislature during the year of 1948.

SPEAKER ANDRESEN Referred to Reference Committee on Report of the Council, Part IX Logislation.

Section 81 (See 132)

Veterans Medical Service Plan of New York, Inc.

Dr. HERBERT H BAUCKUS (Past-President) Mr Speaker and Members of the House of Delegates, this resolution refers to the activities of the Veterans Medical Service Plan of New York, Inc. and if I may have permission for a moment I would like to say that this is the Plan which has made the contract for you with the Veterans Administration You have been taking care of veterans with serviceconnected disabilities under this Plan since Septem-We signed the contract in August, ber 16, 1946 1946, which was a contract for one year, and we are to renegotiate it this year as of August 7, 1947 The Board of Directors of this Plan met yesterday

afternoon, and it is at their request that I introduce

this resolution

I would like to say also that it shall be the effort of the Board of Directors to negotiate the new contract under the same provisions and terms as now exist

At the conclusion of this resolution, Mr Speaker, I would like you to call upon Dr Frederick Lane, who is the chief of the Outpatient Division of the New York State Veterans Administration He is the doctor with whom our Board meets regularly, and I would like to take this opportunity to thank Dr Lane for his cooperation in the past year, and to say that I am delighted he has the viewpoint which we, in general, feel is necessary for the development of good American medicine Dr Lane has with him some charts he may show you He, also, will have an exhibit downstairs in the scientific assembly

"Whereas, the veteran suffering from injury or disease incurred during service in the armed forces deserves not only great sympathy from the community but medical care second to none, and

"Whereas, the State of New York through its Workmen's Compensation Commission provides the highest type of care for its injured workers,

and "WHEREAS, veterans with service-connected disabilities should receive medical care of the same high quality as is now being rendered under Veterans Medical Service Plan of New York, Inc , and

"Whereas, the majority of patients in veteran hospitals are those with nonservice-connected disabilities and the Veterans Administration contemplates the erection of enormously increased facilities, primarily to take care of veterans nonservice-connected disabilities, and

"WHEREAS, it would be false economy to deprive the veterans with service-connected disa-

bilities of the finest medical care, therefore, be it "Resolved, that the Medical Society of the State of New York importune the President of the United States and the Administrator of Veterans Affairs to continue and augment the present 'hometown' medical care program, and be it fur-

"Resolved, that the delegates from the Medical Society of the State of New York are hereby instructed to present a resolution to the House of Delegates of the American Medical Association urging the same consideration for the veterans of the entire United States"

SPEAKER ANDRESEN That will be referred to the Reference Committee on Report of the Council, Part VIII, which is taking up Veterans Affairs, and at Dr Bauckus' request with the permission of the House, if there is no objection, we will call on Dr Lane for the remarks which Dr Bauckus said will be a help to us in introducing this resolution. If there is no objection, I will call on Dr Lane

Section 82 (See 133)

Veterans' Care in Civilian Hospitals

Dr Benjamin M Bernstein, Kings I have another resolution on a similar subject, and we may save time if we hear this first before Dr Lane gets

SPEAKER ANDRESEN How long is it?

DR BERNSTEIN It is very short It will only take a second

SPEAKER ANDRESS N Very well, let us have it DR BFRNSTEIN It is on the same subject, Veterans' Care in Civilian Hospitals, and reads

"Whereas, the present practice permits any physician practicing in the State of New York to care for a veteran for a service-connected con-

dition at home or office, and
"Whereas, the present practice, except in
isolated instances, does not permit the physician caring for this veteran to extend such care to a civilian hospital thus interfering with the continuity of care given to the veteran by his physi-

cian, be it
"Resolved, that the Veterans Administration
be requested to modify this practice in such a way as to permit the continuous care of the veteran by the physician of his choice, either at the veteran's home, at the doctor's office, or in any civilian hospital in which the physician usually cares for his own private patients

SPEAKER ANDRESEN This also is referred to the Reference Committee on Report of the Council, Part VII

Now Dr Lane may we hear from you?

Section 83

Remarks by Dr Frederick Lane, Chief of the Out-Patient Division of the New York State Veterans Administration

DR FREDERICK LANE I would like to present some charts

(Chart) This is what the Medical Care Plan has done between September 16 and March 31, 116,000 veterans were authorized care at a cost of \$3,100,-You can examine these in detail downstairs

in the exhibit

(Chart) Broken down by districts, the New York region, the Greater New York area, weekly authorization, 2,500 is up on top here, veterans authorized weekly, \$120,000 per week. The first decrease here was because the greatest number of veterans had already been sent out for care, and a large number of them were cured in a short period of time. This decrease, which I would rather worry not too much about, was that little difficulty we had with the budget

(Chart) Buffalo region, 2,500 veterans per week,

\$60,000 per week.

(Chart) Albany was our smallest region peak here is 1,300 veterans, average about 600 \$20,000 is the peak, now averaging about \$10,000 per week

(Chart) The Syracuse Office was opened in January, for the Syracuse region, \$20,000, \$15,000 on the average, about 800 veterans authorized care por week

(Chart) This plan of New York State shows the location of the authorizing physicians in the various counties The red stars are the authorizing physicians the blue stars are the coordinators, the men who are employed by the Medical Care Plan to supervise the othical conduct of the physician par ticinants As far as I know, there are only two plans of this kind in the United States New York and New Jersey and from the latest information from those who have observed the various plans they feel that most satisfactory from the point of view of physicians is the New York Plan

(Chart) This is something new in veterans, or in Federal affairs one single page for the authorization for treatment, the certification for treatment the physicians bill and invoice all on one sheet of paper

(Applause)

(Chart) This map shows the various plans in operation throughout the United States. The first the orange color have contracts with intermediaries These are paid a percentage. In Michigan, I think, it is 8 or 10 per cent that is paid to the intermediary There are two that are intermediaries New York and New Jorsey, where there is no surcharge and those two also have coordinators. The green are those where there are agreements with the state medical society no surcharge the physician paid directly Thank you very much! (Applause)

SPEAKER ANDRESEN Are there any further reso-

lutions to be introduced?

Section 84 (See 100)

Head of Federal Health Department to Be a Physician

Dn. Leo F Scmrr Clinton. This resolution is merely to emphasize a certain point in the report of the Planning Committee for Medical Policies and to restate for the record the policy of the Medical Society of the State of New York

WHEREAS, there have been introduced into the Congress of the United States bills having for their objective consolidation of all federal health activities under one head, and there is likelihood that other bills for the same purpose will be introduced, and

WHEREAS, the methods proposed for effecting the consolidation of these activities vary in the various bills, particularly as to the administrative setup whereby in some instances the health activities are only a subordinate part of some other de-

partment boit

Resolved, that the Medical Society of the State of New York believes it to be to the best interests of the people of this country that all Fodoral activities having to do with the public health be consolidated under one head and that such consolidated body be set up as an independent body under the administrative direction of a physician and not be consolidated as part of a department having other functions in addition to the public health.

SPEAKER ANDRESEN Referred to Reference Committee on Report of the Council Part IX, Legisla tion.

Section 85 (See 124)

Medical Practice Committee

DR. DWIGHT V NEEDHAM Onondaga, This resolu tion is introduced on behalf of the Workmen & Compensation Committee of the Onondaga County Medi-While it has already been stated in other words I would like to repeat it

WHEREAR, the county medical societies in the State of New York are bost qualified to determine the qualifications of physician as well as to carry on the other functions devolving upon the medical profession under the Workmen s Compensation Law, including the arbitration of medical bills and

"Witereas, these functions are carried on today efficiently and promptly in those counties having a population of less than one million, by the Work men's Compensation Committees of the County Societies without expense to the State and

Whereas these functions were taken away from the committees of the medical societies in those counties having a population of one million or more and were given in 1944 to a Medical Practice Committee appointed by the Chairman of the Workmen's Compensation Board, and "Whereas this Medical Practice Committee

has not been able to independently carry out these functions successfully and has had to depend upon the cooperation and assistance of the Work men s Componsation Committees of the county

\*\*Resolved, that the Council of the Medical Society of the State of New York, through its Committee on Legislation, be instructed to pro-pare and introduce legislation calling for the abolition of the Medical Practice Committee and the restoration of its functions to the respective county societies."

SPEAKER ANDRESEN Referred to the Reference Committee on Report of the Council Part \ Work-

men a Compensation

Section 86 (See 119)

Practical Nursing

Dr. M R. Bradner Orange I am directed by the Medical Society of Orange County to present this resolution on Practical Nursing

"Whereas the availability of properly trained nurses is obviously inadequate to accomplish hospital and private home requirements and when available such services are costing beyond the financial capacity of the majority of patients

WHEREAS, an estimated two thirds of the population of the county desire and need simple nursing and housekeeping assistance during illness such as is customarily rendered by acceptable practical nurses at charges commensurate with

average family incomes, and
'Whereas acceptable practical nurses can be developed through approved training schedules covering essentials of nursing care either in recognized hospitals or under personal guidance of practicing physicians and such practical nurses can and do become able assistants to physicians within the financial capacity of the average family

WHEREAR, New York State—Chapter 472 of the Laws of 1938-amending the Education Law has prohibited practical nursing except by trained graduates of nine months instruction at special schools and in view of the request of the Board of Rogents that the law be repealed, has al most wholly failed to produce a sufficient number of practical nurses and clearly seems to be against

the public interest and
WHEREAS, all the other states of the union
permit practical nurses to function under the permit frame and the second billy of the practicing physician and twelve of them have abandoned compulsory licensure, therefore, be it Resolved that the Medical Boolety of Orange

County request the Medical Society of New York State to take action leading to the repeal of this

SPEAKER ANDRESEN Referred to the Reference Committee on Report of the Council, Part XII

Are there any further resolutions to be presented?

Section 87 (See 118)

To Provide a More Adequate Supply of Hospital Nurses

DR HENRY E McGARVEY, Westchester resolution is from the Westchester County Medical Society, the subject being "To Provide a More Adequate Supply of Hospital Nurses"

"Whereas, there is a nation-wide nurse shortage of alarming proportions, with recently compiled statistics indicating a national deficit of 40,000 nurses, 16 per cent of the hospitals in the United States with closed beds and 33,000 beds in our hospitals unavailable because of the nurse

shortage, and
"WHEREAS, in the month of April, in New York State, hospitals reported 1,831 closed beds and waiting lists of 8,463 patients, primarily because of

nurse shortages, and "Whereas, the national enrollment of 31,000 students in approved schools of nursing in 1946 was some 13.000 fewer than the schools sought, and approximately 40 per cent fewer than the 1945 enrollment, and

"WHEREAS, this trend and the actual shortage

are of serious concern to the nation's health, and "Whereas, the use of the bedside worker trained to perform many routine tasks in the care of bed patients in hospitals has been proved by wartime experience in both military and civilian hospitals to be an acceptable expedient to supplement the services of available graduate professional nurses to the advantage of the patient's

care, and "Whereas, the New York State Board of Nurse Examiners, while licensing practical nurses with requisite training and qualifications, prohibits the training of practical nurses in any hospital maintaining a school for the training of

graduate professional nurses, and "Whereas, the best facilities for the training of those concerned with the care of the sick are generally to be found in those hospitals with

approved schools of nursing, and "Whereas, short orientation courses for socalled attendants, or nurses-aides, do not appear to offer a satisfactory solution to the problem of better and more adequate bedside care, now, therefore, be it

"Resolved, that the Medical Society of the State of New York go on record as endorsing an extension of the training programs for practical nurses in addition to its continued efforts to increase the available supply of registered professional nurses, and be it further "Resolved, that the standards for these train-

ing programs for practical nurses be maintained at the present acceptable levels prescribed by the State Education Department, and be it further "Resolved, that the Medical Society of the State

of New York, in cooperation with the State Board of Nurse Examiners and the New York State Hospital Association, seek liberalization of the interpretation of existing laws so as to permit the training of practical nurses in all hospitals now conducting training schools for registered, professional nurses, and be it further

"Resolved, that the Medical Society of the State of New York urge the establishment of training programs for practical nurses in approved hospitals not at present conducting a nurse training program of any sort, and be it further

"Resolved, that the American Medical Associa tion be petitioned to take similar action urging similar steps nationally, with the offer of active collaboration with other national bodies concerned

with the training of nurses"

SPEAKER ANDRESEN Referred to the Reference Committee on Report of the Council, Part XII, of which Dr Joseph Gus is the Chairman

Section 88 (See 128)

#### Medical Economics in Medical Schools

DR WILLIAM B RAWLS, New Yorl The subject of this is "Medical Economics in Medical Schools"

"Be it Resolved, that the House of Delegates of the Medical Society of the State of New York instruct its delegates to the American Medical Association to introduce the following resolution

"Whereas, the training of medical students is to a great extent under the direction of full-time teachers who are not, and in many instances were never, engaged in the practice of medicine, and, therefore, are frequently not acquainted with or not in sympathy with the viewpoint of the practitioner of medicine on socio-economic problems.

and
"Whereas, at a previous meeting of the House it was requested by the House that courses in economics be established in medical schools as

soon as feasible, and

"Whereas, such a program was delayed by

the onset of war, therefore, be it "Resolved, that the American Medical Association, through proper channels take active steps to insure the presentation to all medical students in the United States of the viewpoint of the practitioner of medicine on socio-economic problems, and be it further

"Resolved, that the American Medical Association assist in the preparation of the material, the securing of speakers, or in any way that is deemed necessary, to further the institution of such a

program at the earliest possible date'

Speaker Andresen Referred to the Reference Committee on New Business B, of which Dr Frederick W Williams is the Chairman

Section 89 (See 125)

#### Request for Opinion Regarding Compensation Ratings of Physicians

DR PORTER A STEELE, Erre I have been reguested by the Medical Society of the County of Erie to present these two resolutions proposed by the Compensation Committee, one being a request for opinion regarding compensation ratings of physicians as affected by the newly enacted law regarding such ratings

"Whereas, the 1947 State Legislature enacted a law which permits the Chairman of the Workmen's Compensation Board to review and revise the compensation ratings of physicians, and

"WHEREAS, the Chairman may use this power to revise ratings granted before the effective date of

this new law, therefore, be it
"Resolved, that the counsel of the Medical
Society of the State of New York be called upon to

render to the physicians of this State a legal opinion as to whether this new law applies to ratings granted before the law was enacted.

SPEAKER ANDRESEN Referred to the Reference Committee on Report of the Council Part X. Work men a Compensation.

Section 90 (See 99)

Status of Employment of Radiologists by Hospitals on Salary

Dr. Porter A Steels Erie The second concorns the status of employment of radiologists by hospitals on salary

' Whereas, the 1947 State Legislature enacted an amendment to Section 13-c(2) of the Work men a Compensation Law which permits hospitals to employ radiologists on a salary basis and

Whereas, this new law is inconsistent and in conflict with Section 1261-4 of the Education Law and Section 13-d(2g) of the Workmen a Compensation Law which prevent hospitals from employ

ing radiologists on a salary basis and "Wheneas, these statutes will result in a great deal of confusion in the minds of radiologists as to whether they may accept a salary therefore, be

Resolved that the counsel of the Medical Society of the State of New York take legal steps to secure an interpretation of the statutes relating to the permissible financial relationship between hospitals and radiologists.

SPEAKER ANDRESEN Referred to the Reference Committee on Report of the Council Part IX, of which Dr Andrew A Eggston is Chairman.

Are there any other resolutions?

#### Section 81 (Sec 117) Training of Medical Technicians

Dr. ALEX, NEWLANDS, Westchester This resolu-tion is introduced by the County of Westchester and concerns the training of medical technicians

"Whereas, it is self-evident that an essential element of good medical care rests in a large degree upon conscientious and well-trained medical technicians and

Whereas very few colleges or universities in this State offer suitable educational programs for the training of medical technicians, now there-

fore, boilt
Resolved, that the Medical Society of the
State of New York memorialize the colleges and universities of the State, urging them to establish a four year curriculum for the training of medical technologists including a minimum of one year of supervised practical experience in an approved hospital and which will lead to a degree in Medi

cal Technology and be it further
Resolved, that consideration be given to a limited
program consisting of one year in besic courses
and one year of practical hospital training, in which certification may be granted as a Junior

Grade Medical Technologist

SPEAKER ANDRESEN Referred to the Reference Committee on New Business C of which Dr Theodore J Curphey is the Chairman.

#### Section 92 (See 5)

Report of Reference Committee on Reports of Secretary, District Branches, and Censors

Dr. Elton R. Diokson Brooms Concerning the Report of the Secretary your Reference Committee commends the efficient and businesslike manner in which the office of Secretary has been conducted under the leadership of Dr Walter P Anderton. He has given unstintingly of his time and talents in representing our interests within the Society by regular attendance at Council and committee meet-In addition to these regular duties, he has officially visited several national medical groups and worked on two important committees. His staff is a good example of the teamwork necessary for smooth functioning of an office which is so important in carrying on our Society business

In his report it is gratifying to note the election of 1 885 new members during 1946 and the reinstatement of 251 members. Deducting deaths and resignations the net increase for the year is 1 476 members a notable accomplishment. It is deplorable that from this number must be subtracted 188 members dropped for nonpayment of dues. It is difficult to understand why any member should not meet his financial obligation to the organization which is so essential in protecting his interests and so instrumental in keeping him abreast of medical ргостека

It is agreeable to note that the Secretary listed in his report 25 honor societies, all of whose members paid their dues for 1946. It would seem appropriate that each year the Stato Secretary's office should officially make acknowledgment to the local treasurer of an honor society. It is he who bears the

brunt of collecting dues

Your Committee is happy to learn that the long awaited Medical Directory will soon be in our hands. We recognize the many difficulties which have been surmounted in its publication. Its arrival will be welcomed by all members since there have been many changes since the last issue. In view of mounting costs means should be found to supplement it without complling a new edition.

Your Committee on behalf of the Society wishes to extend its appreciation to the Publication Commit The fine work of editing a JOURNAL which is constantly expanding its scope and usefulness the publication of outstanding medical and scientific papers and the various departments which keep our membership informed on pertinent medical affairs deserves our highest commendation.

Our Society is to be congratulated on the election to membership on the Medical Grievance Com-mittee of the New York State Education Department of two outstanding physicians, Dr William W Stroot, of Syracuse, and Dr Clarence P Thomas of Rochester, who will represent our interests well on this most important committee.

Dr Robert Hannon, as Executive Officer in Al bany, has maintained a vigilant attitude over the ever increasing legislative proposals which concern medical practice. He has displayed fine acumen in combating legislation detrimental to our interests and has been instrumental in securing enactment of legislation sponsored by our Society It would be amiss not to mention the fine work of the Legislative It would be Committee, under the chairmanship of Dr Harry Aranow, which works hand in hand with the Executive Officer and the component medical societies.

Your Committee is proud that in capable hands the office of Secretary is carrying forward the tradi tions of the work so important to proper functioning of the New York State Medical Society

Mr Speaker I ask the approval of this portion of

the report, and I so move. DR. FREDERICK S WETHERELL, Onondaga

second the motion.

SPEAKER ANDRESEN The approval of this por-

tion of the report is before you for discussion
DR JAMES R REULING (Treasurer) In the Refer-

ence Committee report, if I understood correctly. there was a recommendation that some way be found to issue a supplementary edition to the Directory If my memory is correct, the Council has already gone on record as directing that immediate steps be continued for the issuance of a new directory probably a year from now That part of the report, if adopted, would negate an action of the Council

The Council took that action, I believe, because of the enormous amount of work and the question of personnel that needs a lot of training in order to

accomplish the thing with a minimum cost

I would like to hear some more discussion on that, probably from Dr Kosmak or Mr Anderson, who could probably give you more information on it than

SPEAKER ANDRESEN Dr Kosmak, do you want

to discuss this?

DR GEORGE W KOSMAK I am very sorry know that my hearing is somewhat defective, but I think it would be good enough if the microphone worked I don't know what Dr Reuling wants me to discuss

DR REULING I will ask the Chairman of the

Reference Committee to reread it

Dr Dickson "In view of the mounting costs, means should be found to supplement it (the Directory) without compiling a new edition"

That is rather a difficult order Dr Kosmak The Publication Committee has already under way the continuation of a directory publication by making arrangements for the retention of a skeleton staff during the interval between the issues of the Directory It was felt in order to keep this information up-to-date, it would be necessary to publish a new volume every year The publication of new volumes in that way will not necessitate the amount of corrections, etc , that were found necessary at the time such a long interval elapsed between the two dates of publication Necessarily, when there is such a long span, a good many changes have to be en-countered We feel that the present volume may contain what might be regarded as errors, but that is something that cannot be avoided because we had to have a date after which no further corrections would be received, but this matter will be taken care of in subsequent issues I trust that explains it

We realize, of course, the great increase in the costs of this particular volume, but we hope by the continuous publication of the Directory a great many of these costs will not be duplicated It was very difficult during this war period to organize a satisfactory staff because of the difficulties in securing appropriate personnel, but I think that Mr Anderson and his staff have done an excellent piece

of work.

The lateness of the issue must, of course, be attributed to printing difficulties and to the lack of the paper supply and labor for binding the volume We have a dummy copy on exhibition down at the JOURNAL exhibit, and we trust that with good luck the Directory may be issued some time during the coming month

DR DICKSON May I ask you a point of informa-tion? When would you plan to publish a new edition?

Dr. Kosmak The idea is to publish a new edition every year

Dr. Reuling Might I ask the permission of the House for Mr Dwight Anderson to speak?

Speaker Andresen Is there any objection to having Mr Anderson speak? Hearing none, will you proceed?

MR DWIGHT ANDERSON Mr Speaker and Members of the House of Delegates, since 1941, as you men all know, and as you are fully aware of from the many questions that have been asked by you of us, there has been no edition of the *Directory* of the Medical Society of the State of New York until the forthcoming issue which will come from the binders in June During this period the Publication Committee, of which Dr Kosmak is Chairman, has made every effort to study other possible ways of supplementing this Directory in order to fill this gap I see some of the men present who have been particularly interested in this special matter because, logically and naturally, their telephone numbers are wrong. their addresses are wrong, and their listings do not comprehend some of the Societies which they have joined and some of the additional and different workmen's compensation ratings that have been given to We have gone fully into the matter of the cost of publishing supplements from time to time the practical impossibility of getting paper during the war, and the difficulty of securing clerical help, it was considered to be simply impossible however, we meet with a little different situation in which it is possible that in 1948 the paper situation

I may say this to you that the paper situation today is worse than it was during the war for the reason that when the limitations of the Government had been removed printing plants, in order to be supplied with paper, especially those getting out current periodicals, purchased paper factories to insure their supply. It is almost impossible to in-It is almost impossible to increase the amount of paper we are able to get, and we were quite fortunate in getting 50 tons for the Directory, which we finally did succeed in obtaining From the best I can learn, the paper situation will

not clear up until 1948

In a supplement to the Directory there would be practically no income You could not sell it, as we do the Directory—we have already sold 1,400 copies of the Directory—to outside people other than the members at a charge of \$12 50 per copy, and we may sell more. These matters of income and advertising all reduce the cost to the Society at that, with the rising cost of labor, the increasing cost of paper, and the increase in the cost of binding and everything else-it has gone up to twice the former cost or one and one-half depending upon the particular item-it did not seem to us feasible (and it does not seem to me to be feasible) to publish a

supplement

Assume that a supplement were published subsequently, then you have the original directory plus a supplement, plus another supplement, plus another supplement, plus another supplement, until we feel that this deficit, which is twice the deficit of 1941 that the Society bears for the 21,200 copies of a book costing us more than \$2 50 apiece just to print, will even be greater If you get these supplements out regularly, there is this question involved You get out your o-iginal directory, the full volume, then you get a supplement out, qua terly, semi-annual, or annual, and you have several supplements lying on your desk, so you have to look up your man in the main directory, and then you have to look him up in supplement one, and then you have to look him up in supplement two, and then you have to look him up in supplement three, all of this, we will say, before the next Directory comes out, and are you going to be satisfied with all of this detail?

Furthermore is your secretary going to have those two three or four supplements and the original directory handy when you want to find somebody?

After talking with a number of men, and visualizing the men who use the Directory sitting there and endeavoring to look up something in it, we felt it would be better less expensive in toto and a greater convenience to the doctor to wait until a new and complete edition were published

I can add this To take care of the compilation problem we have had to augment our staff con siderably We have had to add at least double the number of girls When we are performing the act of sending these cards to the press which is an ad ditional card to the membership files that work has to be practically continuous, and those salaries have to be paid right along so altogether we decided we would prefer to recommend that there be a more frequent edition of the Directory than that the supplement idea be adopted Thank you!

SPEAKER ANDRESEN Thank you Mr Anderson!

DR. REULING As an amendment to the motion, I move to delete that part of the report which deals with the publication of a supplement to the Direc-

The amendment was seconded and as there was no discussion, it was put to a vote and was carried

SPEAKER ANDRESEN The amendment to delete has been passed so now we have the original motion as amended before us for consideration.

Dr. Dickson I move for the approval of this portion of the report with the deletion.

The motion, as amended, was put to a vote, and was unanimously carried.

DR. DICKSON Regarding the Report of the Dis-trict Branches the District Branches during 1946 all held their regular meetings, presenting varied and extremely instructive programs on current medical subjects. They brought to many individual physi cians whose busy lives preclude visiting our teaching centers a day of exceptional postgraduate instruc-

When one reviews attendance, your Committee feels that greater publicity should be made through the local societies to secure the presence of larger numbers of physicians at these meetings. The use of the panel type of discussion with several outstanding medical speakers as moderators may be one answer to this question. Several viewpoints would be presented, thus interesting men in the various specialties in addition to the general practitioner

Your Committee also notes that the President and Secretary as well as many other members of our official family attended all these meetings. This offered opportunity for your state leaders to meet and discuss sectional medical problems with local society members. The members in turn learned how

The Woman's Auxiliary has been represented at all meetings and has extended its activities by interesting local groups in forming new auxiliaries. Your Committee feels that the Auxiliary groups have made a fine contribution to medical progress under the leadership of unselfish and well-informed women

Your Committee believes that the District Branch meetings make a fine intermediary organise tion between the local societies and the State Modical Society Their activities should be aug mented.

Mr Speaker, I ask for approval of this portion of the report, and I so move.

The motion was seconded, and as there was no discussion, it was put to a vote and was unani-

monely carried

Report of the Board of Censor Dr. Dickson Your Committee is happy to report that it was not nocessary to review a report of the Board of Censors there being none This implies that no cases were brought before the Consors for consideration.

Mr Speaker I ask for approval of this portion of

the report and I so move

The motion was seconded, and as there was no discussion, it was put to a vote and was unani mously carried

Dr. Dickson Now I move for the approval of the report as a whole with the deletion already acted upon.

The motion was seconded and as there was no discussion, it was put to a vote and was unanimously carried

Section 93 (See 9)

Report of Reference Committee on Report of Council-Part I Postgraduate Education

DR. CHARLES F ROURKE Schenectady We note that instruction in a wide variety of subjects was provided by speakers selected by this Committee before county medical societies hospital staffs, and other medical groups

Close cooperation was maintained with the State Department of Health, giving further evidence of the desire of this Society to cooperate with all departments of the State Government in matters pertaining

to Medicine

N e further note that arrangements were made for single lectures or a series of lectures for 34 county medical societies or academies of medicine, totaling 142 lectures in all, and for 34 regional meetings and teaching days. The area covered includes practically every part of the state.

Your Committee recommends that the House of Delegator commend Dr Mitchell and his Com mittee for the marvelous work they have done in the past, and that we assure them of our wholehearted

support for their work in the future

Your Reference Committee recommends that the report of Dr Mitchell and his Committee on Postgraduate Education be accepted and I so move.

The motion was seconded and as there was no discussion, it was put to a vote, and was unanimously carried.

Section 94

Report of the Reference Committee on Report of Council—Part XI Publication, Medical Publicity and Contract with Kings County Medical Society

Dr. EUGENE H COON, Nassau The Reference Committee on Report of Council, Part VI Publica-tions and Publicity submits the following report

Publications Your Reference Committee has considered the report of the Council on Publications and read the reports of the Council Committee as reported in the minutes of the Crunell meetings and published in the JOURNAL. We approve of the attractive appearance of the JOURNAL We are especially pleased with the appearance of the Con vention Lesue

Your Committee wishes to comment favorably on the content of the Journal. The popular features Conferences on Therapy and Clinicopathologic Conferences, have been continued and several new departments have been added. These deal with Medical Care Plans, Veterans Administration, Council Meeting minutes, and others These should serve to interest our members and keep them informed about the Society's diversified activities

The Editorial Board notes with pleasure "that our editorials have elicited critical responses from readers and that an increasing number have been quoted in the newspapers and other periodicals' Your Committee concurs in this pleasure and believes it is enjoyment well earned, the result of the careful supervision of the department, the frequent meetings of the Board, the expanded field of editorial writing and, finally, the excellent choice of editorial material

In this regard your Committee would direct your attention anew to a paragraph in the Report of Reference Committee on Report of Council Part XI Publications for 1946, Dr George C Adie reporting

"Your Committee has discussed a new feature which might be added to the JOURNAL This may be called 'Signed Editorial Articles' This section would give members of the profession and recogmized experts an opportunity to express them-selves on current medical problems The adoption of such a plan would in no way alter or be a substitute for the present editorial material It is suggested that space be made for articles which appear to be above the plane of letters to the Editor or personal communications All material submitted as a signed article would be under direct control of the editorial staff and printed at its discretion "

This Committee also suggests that this feature be given due consideration by the Editorial Board and the Publication Committee

Your. Committee is very aware of the acute shortage of paper for the publication and of the printing difficulties and joins with the Publication

Board in asking authors to bear with them

We note that the Publication Committee is slowly but surely conquering the many obstructions which This is a trebar the way to a new directory mendously difficult undertaking in these times, but we are assured that the Directory will be distributed this year June, 1947 A copy for your inspection is on exhibition in the State Society exhibit in the lobby of the auditorium. Your Committee recommends that a skeleton staff be retained and steps taken to publish the Directory annually

Your Committee joins with the Council Committee in acknowledging the efficient and conscientious work of Miss Willma L Simmons and her assistants in the editorial office, of Mr Dwight Anderson, Business Manager, and his associates, of Dr Laurance D Redway and Dr Armitage Whitman in preparing their informative editorials, and of Miss Doris K Dougherty and the members of her staff This spirit of cooperation is not felt by the Council alone, it permeates outward and manifests itself in all parts of the Society, registration desk, district branch meetings and in county society contacts. The entire Medical Society of the State of New York is indeed fortunate to have such loyal workers

And, finally, your Committee recommends that the House of Delegates continue this special committee working under the supervision of the Council, and that the House give the following directive as to

the continuance of its personnel

"The Publication Committee shall consist of the Secretary, the Treaturer, the Executive Secretary, the Managing and Literary Editors, and one member of the Board of Trustees to be appointed by the President of the Society after

consultation with the Chairman of the Board of

I move the adoption of this portion of the report

The motion was seconded, and as there was no discussion, it was put to a vote, and was unani mously carried

Medical Publicity Your Reference Dr Coon Committee wishes to call your attention especially to the ever widening field of activities of the Publicity

Under their guidance, press releases on many topics have been prepared, such as the addresses of our late President Hale before the several district branches, the organization of Veterans Medical Care Plan, Inc , by the Society and the Veterans Administration, and abstracts of scientific papers

which were a part of the 1946 meeting

During the 1947 session of the Legislature the
Committee prepared and distributed reprints of
"Can Chiropractic Cure?" from Hygeia, April, 1946, and Reader's Digest, June, 1946 In addition they prepared handbills which stated our reasons for opposing the chiropractic bill Two representatives of the Publicity Committee were sent to our key

cities to aid the county societies

Efforts are being put forth to establish speakers' bureaus in the various county societies. This is a commendable project which should be embraced by all societies A most valuable and is a 64-page booklet, "Check and Double Check on Sickness Insurance" Over 11,150 copies have been distributed We recommend that every doctor read it

The News Letter has been published several times This is an important service and during the year

we recommend that it be continued

We also note and approve of the assistance given by the Publicity Bureau to the preparation of several articles published in national magazines Colher's, Harper's, Reader's Digest, Hygeia, Vital Speeches, and others

We have read the supplementary report of the Council Committee on Contract with Kings County

Medical Society

We agree that "the Editor of the JOURNAL should be privileged to state to whom books should be sent for review, that the books remain in the hands of the reviewer, and, furthermore, that the Editor of the Journal should have ready for reference all journals received for a definite period

These requests necessitate a modification of the In order to accomplish this your Refercontract ence Committee recommends that the Board of Trustees of the Medical Society of the State of New York sit with the Comitia Minora of the Kings County Medical Society and take steps to modify the contract with Kings County to terminate the agreement entered into in 1904

As regards the second recommendation of the committee "that the Medical Society of the State of New York subscribe to such journals as the Publication Committee considers necessary for its editorial use," your Reference Committee after consultation with the Editorial Board feels that it is unnecessary

I move the adoption of this portion of the report Dr. Frank LaGattuta, Bronz I second the motion.

SPEAKER ANDRESEN This portion of the report is

before you for adoption Is there any discussion?
DR. JOHN J MASTERSON (Trustee) The Medical Society of the County of Kings entered into a contract with the Medical Society of the State of New York many years ago, and the effect of that contract was that all books received by the Society as a result

of exchange in the JOURNAL should be reviewed by the Kings County Medical Society, and the reviewer would return the book to our Society after the book was reviewed. This contract was entered into thirty or forty-odd years ago. We have fulfilled our part of the contract to the letter. All of the books that have been returned to us go into our library. As you know, we have in Kings County our own building, and in it is housed one of the largest medical libraries in the United States.

I would like to know if this resolution in any way violates that contract. As I understood the resolution as presented, the books could now be sent to any reviewer by the Editor and the reviewer retain the book. I say that is in violation of the contract and

should not be passed

DR. GEORGE W KOSMAK (Eddor) My attitude on this arrangement I want to assure you is entirely an impersonal one but let me remind you that when this contract was made forty three years ago, the status of the New York Fatar Stournal of Middle the status of the New York Fatar Stournal of Middle the status of the New York Fatar Stournal of Middle the status of the New York Fatar from what it is today it seems hardly fair to insist that a provision of a contract made so many years ago under entirely different circumstances should be imposed upon the Editorial Committee at the present time. We have every sympathy with the Kings County organization which desires to develop its medical library, but I fail to see why this should be done at the expense of the State Society.

When that contract was made, let me remind you that was at a time when the Kings County Society published a medical journal (I forget the name of it, but it was published in Brooklyn), and it was agreed that the publication of this journal would ceases that it would not compete with the JOURNAL of the State Medical Society Well, since that time the JOURNAL of the State Medical Society has increased to such a degree that the competition need

no longer be feared.

As for these book reviews, it seems rather un reasonable to restrict an activity of this kind to the members of one of our constituent societies. As it is, we publish a note in the Journal that all books for review are to be sent to the offices of the Kings County Medical Society and that has been going on for years. It is difficult for the Editorial Office to keep track of these books. A great many of them are sent direct to the County Society yet the Editorial Committee is responsible for disseminating to the publishers of each book two copies of the Journal in which the review appears. We endeavored a year or so ago to develop a file of all books received but we find it rather difficult because we do not receive any notification from the Kings County Society of their receipt. That is just one of the little difficulties which may, of course, be overcome, but our main contention is that the reviews of books should not be limited to the members of one county society seems to me that the entire medical profession of the state should be called upon to review books for the JOURNAL.

As to the keeping of these books it is the custom of every medical journal to allow the reviewer to make whatever disposition of the book that he wants to make. If the men are delegated to review certain books and want to return them to the library that would be their own affair but why should not a man living in Rochester, for exemple who is equally qualified in that branch of medicine not be asked to review a book and why should he be asked to restore that book to the Kings County Medical Society Library? He may want to give it to the Monros County Society a Library or a man in Buffalo may

want to give it to the Eric County Society's Li brary It seems an unreasonable and unfair arrangement aside from the various technical difficulties to

which I referred

DR. Thomas A. McGoldrick (Past President)
If the books as they are reviewed under the proposed
plan remain in the possession of the reviewer per
manently they will them be of no service to the
editors or the Publication Committee of the State
JOURNAL. They will be out of their possession and
scattered over the State of New York so that the
argument advanced by Dr Koemak for the retention
of the books where they would be at the immediate

service of the editors is not practical

One must remember that there was a contract, to which he refers entered into with the Medical Society of the Kings County Kings County published its journal. It received books and reviewed them As the Editor has stated, the State Journal was not in a very flourishing condition at that time, and the County Society of Kings agreed that it would review the books, send them to individual members to anybody designated in the State Society Journal, and the material was to be furnished to the Journal and all reviews should be published there if the Editor thought well of the That has been going on for these many years.

There has been an announcement always in the Journal of books received and after they have been reviewed they have been returned to this Library of the Kings County whose facilities and resources at hand in the city to editors not only of our State Journal but to others and retained there. They are not in the possession of these individual reviewers at any time The plan has worked out well all through the years These reviews have been made and have been published in the State Jours

NAL

Now it has been proposed, first, to make them available to the editorial department of the Jour NAL. That was the first proposition, but there was no place to store them and develop a brand new library for the Medical Society of the State of New York. They have not room enough for their own administrative purposes, and such facilities are not available at the present time in the City of New York. They do receive the journals and then dispose of them. But this work has been done by Kings County and the books are retained in their library The agreement was made to do this work by their giving up entirely their journal which was a very valuable part of their work.

Thelieve a committee for the State Society looked into this matter for a year of which Dr Poet was the Chairman and as a result of their investigation recommended that while the range of reviewers should be extended, the book could be sent to any body in the State, it should then be sent back to the Library of the County of Kings where it should be maintained in the development of this library and where it could be at hand for editors who are in New York City if the Journal is to be published from there as it has been in the past, and where it would be of the greatest number. It is simply an issue of whether a book is to be retained by a reviewer permanently or whether it is to be made available in a library which is well conducted and at the service of all the medical people and the community itself. For that reason I believe this

resolution should be defeated

If one wished to emphasize that books would be reviewed by men all over the State or out of the State if there are men of special ability and skill in a

particular subject, very well, but having as the gist of it that the books when reviewed, whether the review is acceptable by the editor or not, should be retained in the possession of the reviewer to the detriment of the Library of Kings County is contrary to logic and should be defeated

DR KOSMAK May I have the privilege of the

floor for a moment?

Speaker Andresen Yes

DR KOSMAK In answer to Dr McGoldrick, when I said these books are the property of the reviewer. he seems to think we have no control over the publication of the reviews These books are dispublication of the reviews tributed on the condition that whoever gets them

That is understood must submit a review

I want to emphasize another point that I made. namely, that it seems to me unfair to the membership of the Medical Society of the State of New York to have the reviews restricted to members of the County Society of Kings The distribution of the books for review at the present time is entirely out of the hands of the Editor or Publication Committee The books are distributed locally I, for one, have no control over the reviewers The books are sent out to the people selected by the Kings County group, and it seems to me that it is unfair to the profession of the rest of the State to adhere to that Mr Chairman, I would manner of dong things very much like to hear an expression of opinion from

some of the men who don't reside in Kings County
Dr. Ezra A Wolff, Queens I think that this
recommendation of the Reference Committee in no nav affects the contractual relationship between Kings County and the State Society While it expresses approval of certain modifications of that contract, the recommendation actually calls for simply a conference between the Comitia Minora of the Kings County Society and the Board of Trustees of the State Society From that point of view this discussion of the details of the contract are not par-ticularly relevant, and I think that this House can safely adopt the recommendation of the Reference Committee and allow the discussion between the Trustees and the Comitia Minora to go on with some view in mind of modification

SPEAKER ANDRESEN Thank you for clarifying that! The passage of this resolution, of course, will not affect the contract that has been in existence for

forty-three years

DR MASTERSON If there-

SPEAKER ANDRESEN We must confine ourselves to the rules of the House, one of which is that there can only be one discussion by one man on a par-

ticular subject

Dr Masterson As a point of order, Dr Kosmak was given the privilege of the floor twice to discuss this I was only going to speak just the once, but since you recognized Dr Kosmak twice, I would like to ask that that part of the report wherein it is stated that the reviewer would keep that book be read because that is in violation of our contract, and this House has no authority to abrogate that contract without Kings County's agreeing to it
SPEAKER ANDRESEN There is no violation of the

contract Do you want to make an amendment?

DR MASTERSON I understood that in some part of that resolution that would be the effect of it if adopted

SPEAKER ANDRESEN Then why not amend it? DR MASTERSON I only wanted it read in order to clarify this situation

DR McGoldrick Read just that part of it

DR COON It reads

"We have read the supplementary report of the

Council Committee on Contract with Kings

County Medical Society

"We agree that 'the Editor of the Journal should be privileged to state to whom books should be sent for review, that the books remain in the hands of the reviewer, and furthermore, that the Editor of the JOURNAL should have ready for reference all Journals received for a definite period

"These requests necessitate a modification of the contract. In order to accomplish this your Reference Committee recommends that the Board of Trustees of the Medical Society of the State of New York sit with the Comitia Minora of the Kings County Medical Society and take steps to modify the contract with Kings County to terminate the agreement entered into in 1904"

DR JAMES F ROONLY (Trustee) I am speaking to this motion, the motion to adopt the report of the Reference Committee Am I in order?
SPEAKER ANDRESEN Yes, sir

Dr. Rooney I am glad to hear it This matter has been up before every House of Delegates for the last twenty-five years I think it is about time it should be settled However, I feel there is perhaps an error on the part of the Committee in knowing the proper group in the Society to which this matter should be referred. It should not be the Board of Trustees, and I am merely speaking to that point, it should be a committee of the Council because the Board of Trustees has no right to make any policy The Board of Trustees can act on contracts only when the Council has referred the matter to them with their approval or diapproval, so I move to amend that report by substituting the words "referred to the Council in conjunction with the Comitia Minora of the Kings County Society for their determination and such reference as may be needed in relation to the continuance or the termination of such a contract " I move that as an amendment

DR. FREDERICK W WILLIAMS, Bronx I second

the amendment

Dr. ROONEY Later I would like to have the privilege of making another motion after I know whether that has been accepted or not

Speaker Andresen Is there any discussion of

the amendment?

May I read from the SECRETARY ANDERTON Bylaws of the Society in keeping with what Dr Rooney has said, from Section 2, of Chapter V, in regard to the Board of Trustees

"The Board of Trustees shall have charge of all property including trust funds and shall supervise the financial affairs of the Society and shall invest the surplus from time to time. The budget prepared by the Council shall be submitted to the Board for its approval and all resolutions or recom-mendations of the House of Delegates or Council pertaining to expenditures of money must be ap proved by the Board of Trustees before the same shall become effective The Board of Trustees shall make and execute all contracts for the Society," etc

Then under Section 2, of Chapter IV, in regard to the Council, it says

"The Council shall meet at the close of the annual meeting of the House of Delegates," etc

And Section 1, of Chapter IV, provides

"The Council shall be the Executive and Administrative body of the Society while the House of Delegates is not in session and shall control all arrangements for the annual meeting etc.

The Bylaws are distinctly what Dr Rooney has

enunciated SPEAKER ANDRESEN If there is no further discussion, we will now vote on the question which

substitutes Council for Trustees and is practically the same in other respects DR. THOMAS M D'ANGELO Queens Point of order it goes much further than that Dr Rooney

said whether the contract should be terminated or

continued DR. ROONEY You are quite correct I think the

stenographer has that. SPEAKER ANDRESEN Yes but essentially it was

the change I mentioned The question on the amendment was called,

and it was put to a vote and was carried Speaker Ambresin We will go back SPEAKER ANDRESHN We will go back then to the original motion as amended Is there any discussion? The question was called and it was put to a

vote and was carried

Dr. Roomer You are speaking now to the Report of the Committee as amended so I think I have the right under those circumstances to speak again

to the amended motion.

It seems to me gentlemen, we ought to dispose of this thing for good We have taken up at least an hour and a half to two hours of every meeting of the House of Delegates or every other meeting of the House, and I can remember when we took up four hours discussing this thing It is a most point I have listened to the arguments pro and con, and I am not going to speak of those I leave those to your discretion. I think we should refer this whole matter to the Council with the power to take the determinative and finishing action, and I so move Dr. Frederick W Williams Bronz I second

the motion.

DR. McGoldrick May I ask what is meant by 'finishing' -finishing in determining the question or the matter of the contract?

Dr. Rooney May I answer that Mr Speaker?

SPEAKER ANDRESEN Yes.

Dr. ROONEY My idea is this Let us settle this matter and let us terminate this contract if that is what the Council feels should be done, or let us write a contract that is definite in terms and for ninety nine years and let us get done with it My motion means it leaves to the Council that privilege or that right and that power It seems to me that in here and late in the morning beesion with our getting pretty close to no quorum we might better send this to a deliberative body that would have an oppor tunity to cover all facets and to consider them. I know that the Council will not according to your will

DR. EZRA A. WOLFF Queens On this motion to refer with power to act I don't think that Dr Rooney is taking into full consideration that this is a bilateral contract this is not unilateral on the part of the State Society alone From my point of view the Kings County Society has a contract which it can, if it will hold the State Society to for as long as the term of the contract goes and I think it is only by the consent of the Kings County Society that any modification can be made. If it is in the hope that the Council can induce them to consent to such modification I think that this amended motion should be passed by the House

SPEAKER ANDRESEN This is a motion to refer and I believe Dr Rooney's motion will take that into consideration. The idea is to finish the dis-

cussion.

Dr. ROONEY May I have the brief privilege for merely one second to reply to that? I understand perfectly well that all contracts are bilateral You cannot enter into a contract with yourself and have It bind you You may make a vow but that is another matter This matter is immediate. The intent of my motion was that a Committee of the Council with the Comitia Minora of Kings County should meet and settle this thing. That means another meeting of minds and between them they will determine whether to continue or terminate the contract, and it must meet the will of both parties I don t think your objection is quite valid therefore.

The question was called on the motion to refer, and it was put to a vote and was carried.

SPEAKER ANDRESEN We are very late now

are supposed to meet again at two o clock I don t know how we can eat in that time so we will make it 2 15

(At 1 15 o clock Par. a recess was taken )

(To be continued in the October 15 issue)

#### FORTY-FIRST ANNUAL MEETINGS

of the

#### DISTRICT BRANCHES

of the

#### MEDICAL SOCIETY OF THE STATE OF NEW YORK

#### **PROGRAMS**

#### Second District Branch

Wednesdy, October 29, 1947

Garden City Hotel

#### Morning Session

11 00 A M.—"The Management of Gastrointestinal Problems of the Upper Abdomen" -Panel Discussion

Albert F R Andresen. Moderator M D, professor of clinical medi-cine, Long Island College of Medi-

Frank Glenn, M.D., professor of surgery, Cornell University Medical College

Edward Weiss, M D, professor of clinical medicine, Temple Uni-versity School of Medicine, Phila-

delphia, Pennsylvania
A L Loomis Bell, M D, professor of
radiology, Long Island College of Medicine

John Russell Twiss, M.D., associate clinical professor of medicine, New Post-Graduate Medical School and Hospital

Burrill B Crohn, M D, consulting gastroenterologist, Mount Smai Hospital, New York City

1 00 PM -Luncheon

Address by Louis H Bauer, MD,
President, Medical Society of the
State of New York

Remarks by Mrs Harry F Pohlmann. President of the Woman's Auxiliary to the Medical Society of the State of New York

#### Afternoon Session

2 30 r w - "Hermation of Intervertebral Disks Cervical and Lumbar

E Jefferson Browder, MD, pro-fessor of clinical surgery, Long Island College of Medicing, director of surgery, College Division, Kings County Hospital

The Woman's Auxiliaries of the four County Medical Societies on Long Island will attend the luncheon and will hold a meeting at the Garden City Hotel in connection with the meeting of the Second District Branch (Notice of this meeting will be mailed to the members of each of these auxiliaries) Bridge will follow

Reservations for the luncheon must be made in Send check for \$3 50 per plate to Charles advance F McCarty, M D , 1313 Bedford Avenue, Brooklyn, New York

#### Officers-Second District Branch

John B D'Albora, M D Brooklyn President First Vice-President Charles C Murphy, M D, Amityville

Second Vice-President Thomas M D'Angelo, M D. Jackson Heights Charles F McCarty, MD,

Secretary-Treasurer Brooklyn

#### Presidents of Component County Societies

Kings Abraham Koplowitz, MD, Brooklyn E Kenneth Horton, MD. Nassau

Rockville Centre Goodwin A Distler, M D, Queens

Woodhaven Thomas W Faulkner, MD, Suffolk Huntington

#### Fourth District Branch

Thursday, October 23, 1947

Elks' Club, Amsterdam, New York

#### Afternoon Session

2 30 P M — "Surgical Treatment of Hypertension" David P Boyd, MD, FRCS(C), Amsterdam

"Present Status and Future of Medical Care Insurance in New York State"

George P Farrell, director Bureau of Medical Care Insurance Medical Society of the State of New York

"The Use of BCG Vaccine in the Control of Tuberculosis'

[Continued on page 2136]

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Robert E Plunkett, M D, Albany, assistant commissioner for tuberculosis control, New York State Department of Health

"Legal Difficulties Frequently Encountered by Practitioners of Medicine" Thomas H. Clearwater, Fsq , attorney for Medical Society of the State of

New York "Problems and Trends in Nursing" Grace G Appleton, BS, MA., director of nursing education, State Teachers College, Plattsburg, Committee on Careers in Nursing, New York State Nurses Association (By

invitation) "Cancer of the Large Bowel and Rectum"—with Lantern Slide Demon-

Charles Gordon Heyd, M D, New York City, professor of surgery, Post-Graduate School, Columbia University, attending surgeon, Post-Graduate Hospital

Problems and Accomplishments of the Workmen's Compensation Committee

"Over the Past Year"

Joseph P Henry, M D, Rochester, member of Council Committee on Workmen's Compensation, Medical Society of the State of New York

"The Years Ahead"

J Stanley Kenney, M D, New York City, chairman, Council Committee on Workmen's Compensation, Medical Society of the State of New York

7 00 P M -- Dinner

Address by Louis H Bauer, M D . Presi dent, Medical Society of the State of New York

Ladies will join members of the District Branch for dinner

Officers—Fourth District Branch

President Denver M Vickers, M D Cambridge Joseph A Geis, MD First Vice-President Lake Placid G S Pesquera, M D Second Vice-President William E Gazeley, M D Secretary Schenectady Treasurer J Frederick Sarno, M.D., Johnstown

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Cambridge

#### FORTY-SECOND ANNUAL MEETING

of the

#### EIGHTH DISTRICT BRANCH

#### PROGRAM

Wednesday, October 1, 1947 Hotel Jamestown, Jamestown

#### Morning session

10 00 A M -- "Hypoglycemia"

Edgar C Beck, M D, assistant professor of medicine, University of Buffalo, School of Medicine

11 00 AM — "The Significance of Laboratory Findings in the Diagnosis and Treatment of Disease"

John H Talbott, M D, professor of medicine, University of Buffalo, medicine, University School of Medicine

12 30 PM -Luncheon

Address by Louis H Bauer, MD

President, Medical Society of the State of New York
Introduction of Mrs Harry F Pohlmann, President of the Woman's Auxiliary to the Medical Society of the State of New York
Business Meeting—Election of Officers

#### Afternoon Session

2 30 р м —Symposium on Cancer Therapy "The Results of Experiments and Clini

cal Investigation of the Newer Agents in the Treatment of Can-

cer'

Louis C Kress, M D, director, Roswell Park Memorial Institute, Buffalo

"Advances in the Use of X-ray and Radium in the Treatment of Cancer'

Walter T Murphy, M D, radiologist, Roswell Park Memorial Institute, Buffalo

'New Surgical Methods in the Treatment of Cancer"

Joseph E Macmanus, M D, instructor in surgery, University of Buffalo

School of Medicine

[Continued on page 2138]

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#### The General-Practitioner

To the Editor

In a special article, "Is General Practice Becoming A Specialty?", published in the April 15 issue of the Journal, Dr H L Nelms declares the general practitioner is a scientific and economic necessity, who "should not be discriminated against in fees, prestige, or hospital privileges, and should be given adequate recognition with the specialist for his competence and ability" He also calls upon the "profession itself to convince the public of the importance

and necessity of the general practitioner," etc
Undoubtedly, this is a laudable defense of the
general practitioner
But, here again, we come in
conflict with theory and practice, with fact and

fancy

Our hospitals recently have passed rules that only men certified in obstetrics can bring in obstetric Here is frank discrimination against the general practitioner, in a field that was always considered the domain of the general practitioner

The general practitioner is, therefore, ofheially disqualified in his practice and prevented from practicing obsetetries unless it is done either in the home or in a private sanitarium

If the profession itself is not convinced of the general practitioner's competence in obstetrics, how futile it is to expect the "profession to convince the

public of the importance and absolute necessity of the general practitioner"

The real motives that inspired obstetricians to impose this restriction on the general practitioner should be investigated. Such behavior might be expected among competitive business groups, not in our "honorable, ethical" profession Indeed, I beheve our profession, too, needs to be psychoanalyzed

May 2, 1947 (Signed) B GARRISON LIPTON, M 1) 161 West 86th Street New York City

#### Response by Dr Nelms

To the Editor

I am glad you sent me Doctor Lipton's letter for it adds to a long list of written and personal com-ments I have received since your publication of my vice-presidential address entitled "Is General Prac-

tice Becoming a Specialty?"

The letter deals specifically with obstetrics and opens a wide field for discussion One cannot logically quarrel with the hospital management that seeks to insure the best type of obstetric care for its patients and by the same token a practitioner who can demonstrate his competence by training and experience in this field should not arbitrarily be denied the privileges to which his competence entitles him simply because he is a general practitioner

(Signed) Homer L Nelms, M D Albany, New York July 19, 1947

Note -In relation to the foregoing, attention may be directed to a statement in the report made to the recent meeting of the House of Delegates of the American Medical Association (See page 7121, Journal of the American Medical Association, June 21, 1947) "There should be an organized staff of 21, 1947) ethical, licensed physicians holding the degree of doctor of medicine from approved medical schools acceptable to the Council on Medical Education and Hospitals The particular specialties in which residents are being trained should be represented on the staff by well-qualified, experienced, and profi-cient physicians, whether or not they may be certified

in a specialty or gold membership in special societies". It may be added that certain "Boards," such as the American Board of Diplomates in Obstetrics and Gynecology, have declared that they impose no re-restrictions on hospital appointments, that such action has been developed by individual institutions

The Editor

#### EIGHTH DISTRICT BRANCH MEETING

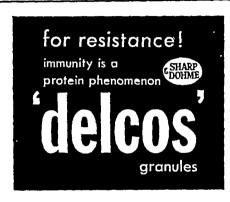
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Ladies will join the members of the District Presidents of Component County Societies Branch for luncheon Allegany Irwin Felsen, M.D., Wellsville Cattaraugus Officers—Eighth District Branch Ronald F Garvey, M D, Olean President Chautauqua William Frank P Goodwin, MD, Jame~ J Orr. M D Buffalo First Vice-President Robert C Peale, MD, Erie Arthur F Glaeser, M D, Buffalo Olean Genesee S L McLouth, M D, Corfu Second Vice-President John C Kinzly, MD. Niagara North Tonawanda John C Kinzly, M D, North Tona wanda Secretary Henry S Martin, MD, Orleans Warsaw Edward T Eggert, M D , Knowle-Ralph M Bruck M D , Cassadaga Treasurer Bruckheimer, Wyoming Willard J Chapin, M D , Perry

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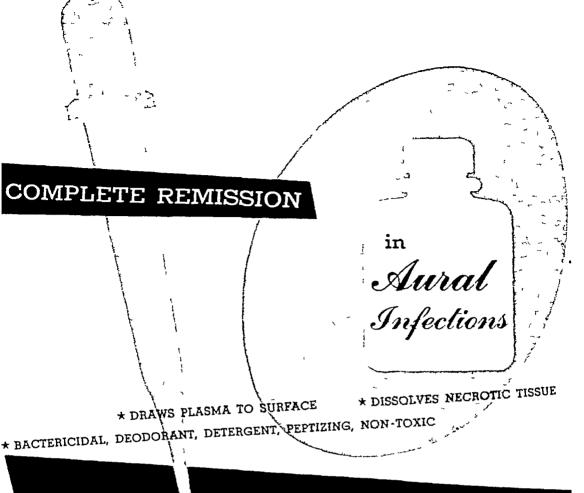
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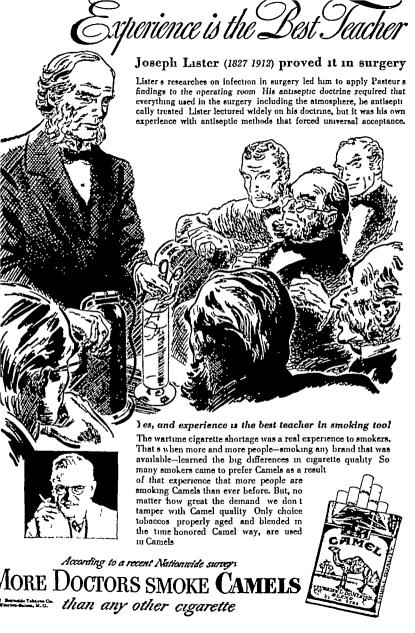
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NUMBER 20

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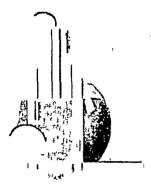
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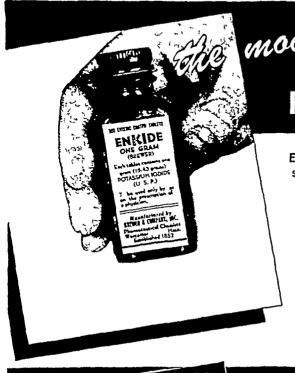
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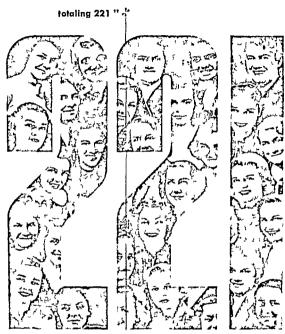
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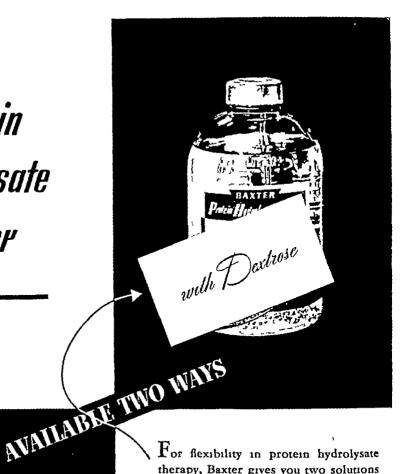
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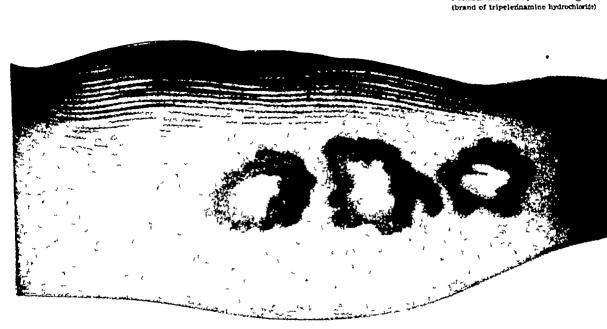
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OSBORNE, JORDON & RAUSCH Archives of Dermatology & Syphilology, March 1947

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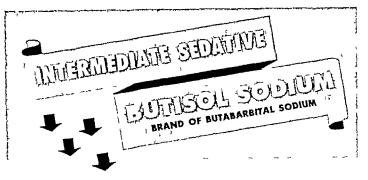
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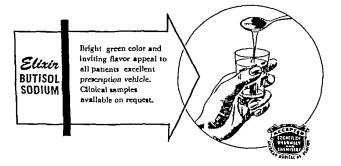




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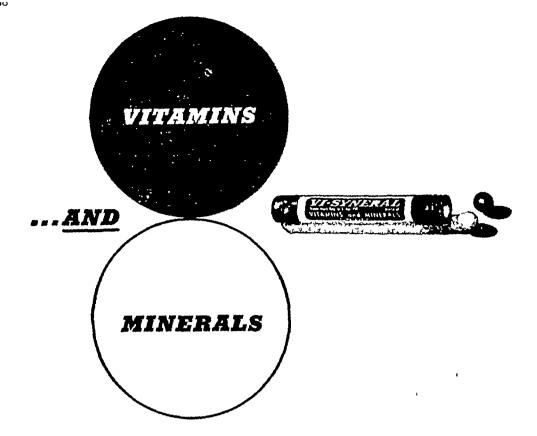
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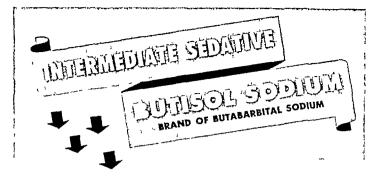
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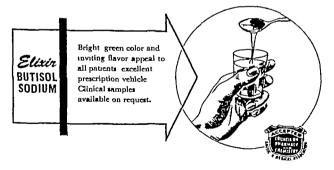
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DOSAGE FORMS: Elixir Buthol Sodium 0.2 Gm. (3 gr.) per fl. oz.—in pints.

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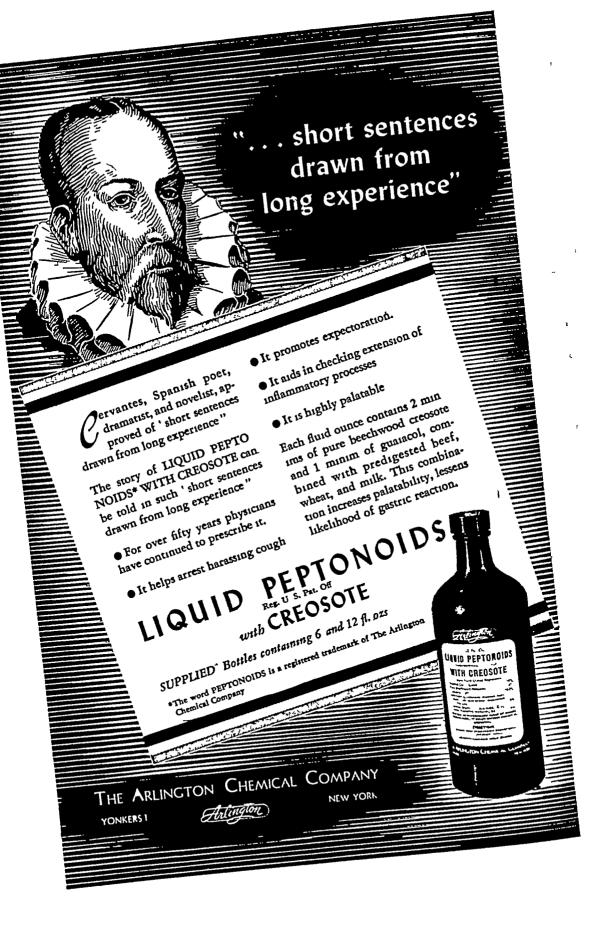
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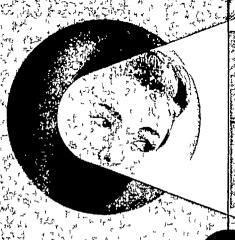


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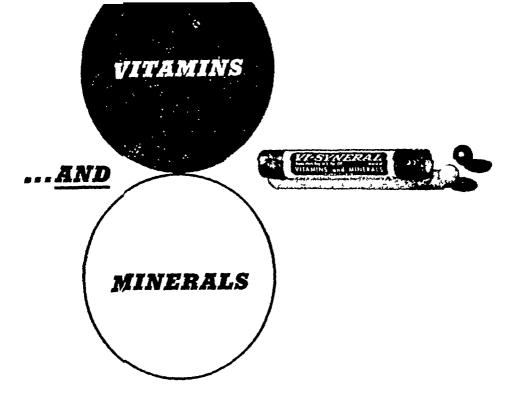
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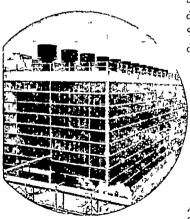
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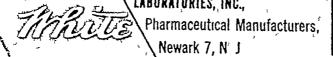
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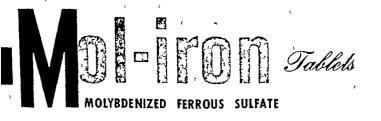
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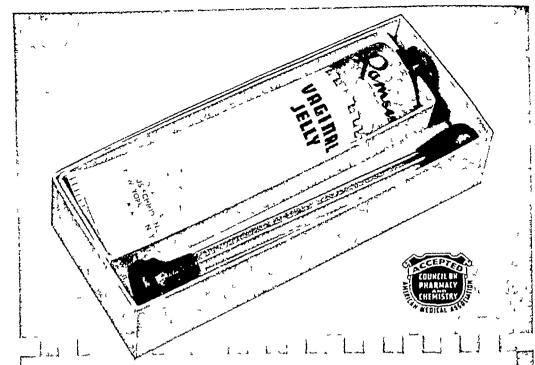
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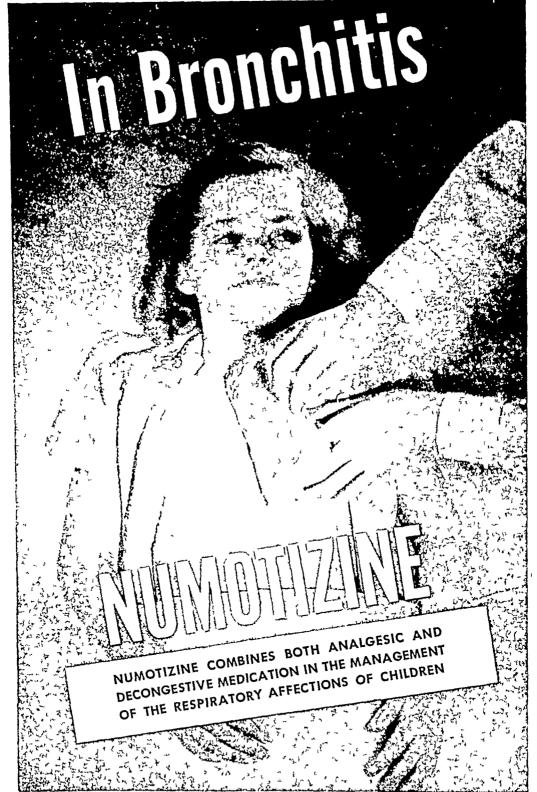
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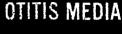


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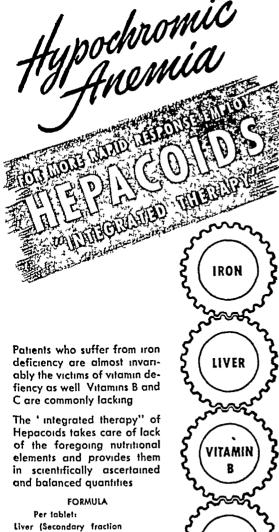
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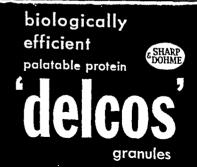


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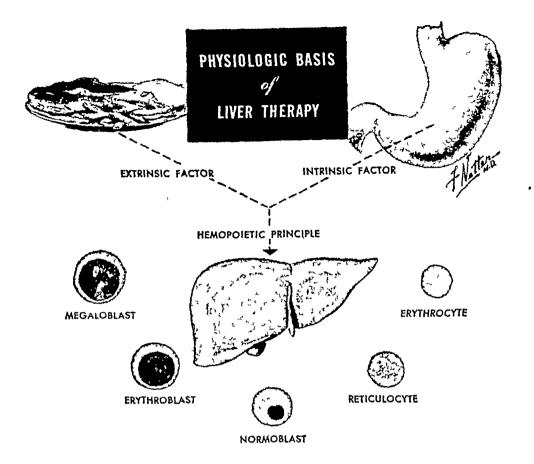




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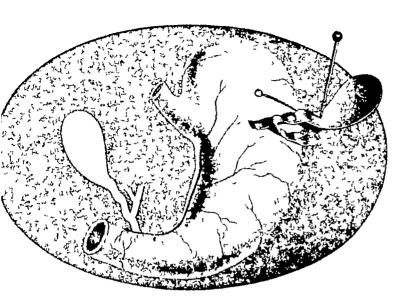
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### Bile in the Stomach?



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**VOLUME 47** 

OCTOBER 15 1947

NUMBER 20

#### Editorials

#### Prepayment Plan Progress

With the year 1948 coming up, one may anticipate an intensified campaign to change the methods by which medical service in these United States is produced, distributed, and paid for

Change there must be But it should be based on proved need and proceed in general along lines consonant with the orderly scientific, social, and economic development of the nation

As this is written it seems clear that an already muddled attention with respect to changing the bases of medical service is about to be befogged further by the missmic vapors of a political campaign. It is un fortunate that this cannot be avoided, that the future status of medical service for the United States cannot be approached, discussed, and planned by informed debate and careful examination of the facts, apart from the heat and haze of political turmoil

In the State of New York voluntary medical insurance, one of the sound well-planned methods of providing medical service which has the approval of the medical profession, has increased its membership 43 3 per cent in the first six months of 1947, the total enrollment as of June 30 being 860,703 members. During the same period

in 1946, membership increase was less by 104,356, thus the increase in the first half of 1947 exceeded the same period a year ago by 66 6 per cent

Benefits to members for the first six months of 1947 were \$1,460,770 Benefits to members for the same period in 1946 were \$684,797 The increase in benefits during the first six months of 1947 was \$775,973, or 113 3 per cent

At the present rate of growth, membership as of December 31, 1947, should well exceed our prediction of 1 000 000, and total benefits of over \$3,500,000 to members since the plans began operation

Throughout the nation, according to the Council on Medical Service of the A.M.A.¹ over six million enrollment is noted in medical-society-sponsored prepayment plans as of June 30 of this year. The number of plans continues to increase, enrollment in existing plans grows by leaps and bounds Eighteen plans have a total enrollment of over 100,000, eight others of 50,000 to 100 000, ten more of 25,000 to 50,000 Percentage gains of plans in widely scattered geographic areas of the country during the first half of 1947 range from 4.9 per cent to

1 News Letter 4: 2 (Aug. 30) 1947

763 2 per cent, with an average of 31 per cent

Certainly such percentage increases as are here indicated attest the acceptability of these plans to both the medical profession and the public. The plans stand on their own feet and on the actual ment of the service they provide. It is claimed and will undoubtedly be ballyhooed in the forthcoming political campaign that the principle of voluntary prepayment is a failure, that the plans operating on this principle have not measured up to the demand of the

public, that nothing short of compulsory health insurance can possibly suffice

Neither the principle nor the plans have failed. Not one prepayment plan "developed by medical societies has failed since 1939". That is the fact "In only two states is no plan for prepayment for medical care in process of development". Certainly, the record is not perfect. It does show progress. It shows also the kind of progress, achieved the hard way, which is enduring

<sup>3</sup> Minnesota Med 30 382 (April) 1947

#### How Do You Click?

The recent annual Safety Convention and Exposition held in New York under the auspices of the Greater New York Safety Council for its seventeenth session faced an appalling future. The coming jet and atom age holds prospects that should delight the soul of the writers of grisly tales and make the work of accident prevention a maze of bewildering difficulties.

The experience of man in the evolution of this civilization, from an agrarian era through its subsequent changes based on the application of power to tools of all kinds, has been increasingly unhappy in terms of wastage of human life through accidents. In the application of steam, subsequently electricity, and then gas as a propellant, man has been equipped through his own perceptive mechanisms with the means to become aware of the noxious potentialities of the forces with which he dealt

The exposure to accidental injury and the effect were, if not simultaneous, at least reasonably so As illustration, if a kettle of boiling water accidentally spilled on you, the burn resulted immediately and pain-If you accidentally touched a spark plug while your automobile engine was running, you got instantaneous results of which you became painfully aware These simple cause-and-result relationships were within the comprehension of most people and within their actual but not fatal experience with boiling water, steam, and electricity in daily The point here is that ordinary every-1186

day pedestrian bus-dodgers, barrel-clad taxpayers, or commuters had some conception of what it was all about

The principle of jet propulsion, though not yet in the common experience of the man on the street, is not so radically different from gas-engine-propeller operation or from the Fourth of July rocket as to be incomprehensible. Use of the jet does introduce a new element however, greater height and speed.

What the effect of this will be on accident forecast does not now seem predictable But stratosphere travel, pressurized cabins, supersonic velocities of planes present vistas which give one to think What price dodging falling debris? Ask the British

Release of atomic energy, however, is a horse of a different color Away back in the early days of the x-rays, man learned of a different variety of noxious agent against which his five senses gave him no warning Even his so-called sixth sense was not Long after exposure to the radiation, men began to lose fingers, then whole hands, eventually lives The tragic stories of the girls who, with their lips and tongues, pointed brushes for painting clock hands and dials with radium paint and who subsequently perished from slowly wasting disease will be remembered as examples of what the atomic age holds in store for mankind and those concerned with accident prevention

Injury by radiation presents the problem of providing otherwise unaware people with some means of knowing that they are dangerously exposed to it. Ask any surviving inhabitant of Hiroshima or Nagasaki. The atom bomb has this advantage that everyone who survives the blast has at least been warned. But, even so, the warning is of little use, because once human tissue is expected, certain progressive changes have been started which inevitably continue. No one knows with certainty as yet the duration of

radioactivity of substances once activated Dusts, water, land, and the components thereof become lethal for unknown periods of time

Education looking toward accident prevention in the atomic age will be no simple matter of passing out cards to people on street corners urging caution. It may come to the point where individual Geiger counters must always be carried by everyone and the cheerful "good-morning" give way to "how do you click?"

#### Current Editorial Comment

Venous Catheterization of the Heart Surgery of the heart and blood vessels has now advanced to the point of cure or improvement of certain types of congenital heart defects Venous catheterization of the heart may be helpful in making an accurate preoperative diagnosis Previous reports have been concerned chiefly with the study of cerebral, renal, and hepatic physiology in health and disease, but, more recently, catheterization of the heart has been found to have practical applications, particularly in the study of congenital heart disease Merrill C Sosman' reports on the indications, technics, and errors, and Lewis Dexter<sup>2</sup> on the results, interpretations, and value of this procedure in 100 examinations

The catheter, size 9 French, of woven silk, radiopaque, 100 to 125 cc in length, flexible but stiff enough to be rotated without buckling, is passed into the median basilic vein through a surgically clean incision in either the right or left antecubital space catheter then is threaded into the vein. advanced under fluoroscopic guidance into the axillary vein, the superior vena cava, and the right nuricle From there it may be passed downward into the inferior vena cava, the right or left renal vein, other chambers of the heart, the pulmonary vessels, or into one of the hepatic veins Clotting of blood in the catheter is prevented by a continuous perfusion of normal saline from a reservoir, at a rate of 15 to 60 drops per minute The procedure requires a minimum of three persons trained for proficiency in teamwork Of the 100 exam mations, only 13 were unsatisfactory Subjective symptoms severe enough to cause abandonment of the examination were observed in only two instances

Venous catheterization of the heart has been helpful in making a diagnosis of auricular septal defect, ventricular septal defect, tetralogy of Fallot, and in patent The findings by the ductus arteriosus method of catheterization "should be used in conjunction with the usual procedures of history, physical examination, electrocardiography, fluoroscopy, and, if available, the Robb-Steinberg technic of visualization of the cardiac chambers with diodrast" In more than 1,300 examinations involving the use of a catheter in the heart (100 by the authors and more than 1,200 by others), the authors know of only one fatality It followed the injection of diodrast through the catheter in a patient who had been injected with the same medium ten days previously

The Clinical Use of Anticoagulants Under the above title, Allen' makes an admirable presentation of the dangers of thrombosis and embolism. For centuries physicians have been aware of the dangers of hemorrhage and have devised means for its control and prevention. Only during the past twenty years, however, has there been a progressively increasing realization and understanding that blood within the vascular system may clot too easily and too well Recent knowledge indicates that hemorrhage causes fewer deaths than intravascular thrombosis. The American Red Cross First Aid textbook (1940) appropriately places serious hemorrhage at the head of the list

<sup>&</sup>lt;sup>1</sup> Sosman, Merrill C : Radiology 48: 441–450 (May) 1947 <sup>3</sup> Duxter Lawis: Radiology 48: 451–462 (May) 1947

<sup>1</sup> Allen, Edwar V : J.A.M.A 134: 523 (May 24) 1947

of emergencies requiring immediate treatment. The dangers of acute bleeding often are quickly apparent and rapidly serious. On the other hand, the greater total dangers of thrombosis are at times insidious, lurking, slowly apparent, and some of its serious consequences may be long delayed.

To overcome the excessive tendency of blood to clot within the vessels, there are now available two anticoagulants heparin and dicumarol Both have the disadvantage that, when used to excess or without due care and supervision, they may cause hemorrhage Although neither drug is an ideal preparation, both heparin and dicumarol have been, and are being, used with great benefit

The relative advantages of heparin are quick effect, quick disappearance, necessity to have laboratory control disadvantages are expense and need of parenteral administration The advantages of dicumarol are its inexpensiveness and effectiveness orally Its disadvantages are delayed effect, continued effect for days after discontinuing, and need for laboratory daily determination of pro-The author makes a plea to thrombin time discontinue reporting prothrombin time Instead of reporting the time in seconds, he recommends that all laboratories uniformly report the prothrombin in percentage of As a minimum, he suggests that "every publication should contain the prothrombin time for three critical values of prothrombin, 30 per cent, 20 per cent, and 10 per cent" Deficiencies of prothrombin, with hemorrhage from the use of dicumarol, may be corrected by giving one grain of vitamin K intravenously, or a transfusion of 500 cc of fresh blood

The indications for anticoagulant therapy are (1) after nonfatal pulmonary embolism. (2) for thrombophlebitis and phlebothrombosis, (3) sudden arterial occlusion (embolism and thrombosis), (4) in traumatic cases to avoid thrombosis, (5) postoperative cases with a history of previous thrombosis and embolism, and (6) after abdominal hysterectomy Anticoagulants possibly may be beneficial in acute myocardial infarction, congestive heart failure, and in arrhythmias, particularly auricular fibrillation coagulants should be used cautiously or not at all in (1) deficiencies of ascorbic acid and vitamin K, and in diseases of the liver, (2) renal insufficiencies, (3) blood dyscrasias, (4) recent surgical operations on the brain or spinal cord, and (5) ulcers or open wounds

Among 1,686 postoperative cases, minor hemorrhage occurred in 31 per cent, and major hemorrhage in 19 per cent. There were two deaths from hemorrhage, one not caused by dicumarol, in the other the cause remained in doubt. The results in 280 cases of postoperative thrombophlebitis were as follows.

C	Expected If Antı- coagulants Were Not		
	Used	Occurred	
Subsequent venous thrombosis or pul- monary embolism	68	8	
Fatal pulmonary em-			
bolism	16	0	
n 716 cases of abdominal Venous thrombosis or pulmonary embolism	hystere	ectomy 2	
Fatal pulmonary em-	20	-	

In 292 cases of pulmonary embolism
Subsequent venous
thrombosis or pulmonary embolism
127
3
Fatal pulmonary embolism
53
1

5

0

bolism

In considering the relative merits of anticoagulants and ligation of veins, the author believes the former give the best results, with one exception After repeated thrombosis and pulmonary embolism over periods of weeks or months, ligation may be preferred because of the difficulties of using anticoagulants over a long period the 1,686 cases reported, it appears that 73 lives were saved, and 211 patients escaped venous thrombosis and pulmonary embolism by the use of dicumarol Since thrombosis causes more deaths than hemorrhage, more attention must be given to the need and the means of impairing the ability of blood to clot within blood vessels

#### Scientific Articles

#### INTRAVENOUS PROCAINE A PRELIMINARY REPORT

DAVID J GRAUBARD, M.D. RAPHAEL W. ROBERTAZZI, M.D., and MILTON C. PETERSON, M.D. New York City

(From the Traumatic Surgery and Anesthesia Services of the Reconstruction Hospital Unit New York Poel Graduate Medical School and Hospital)

PROCAINE hydrochloride has been used for a number of years as a local anesthetic agent Though the present interest in the intravenous use of this drug may seem new and contrary to the generally accepted procedures, Bier1-2 in 1908 read a paper entitled "On a New Method of Producing Anesthesia in the Extremities" His method consisted of injecting processes into a superficial vein in a given area of a limb which had previously been depleted of blood by the use of bandage and tourniquet The method was not widely accepted in England4 and the United States. At about this time vasopressor drugs were added to solutions of local anesthetic agents to produce local achemia. The addition of the vasopressors to the local anesthetic agents resulted in a sharp rise in the mortality rate with consequent abandonment of the intravenous route. It has been suggested that the cause of death following procesine-epinephrine injection may be due to epinephrine . However, it must be borne in mind that procaine in itself is a toxic drug, whose toxicity is increased three-fold by the addition of epinephrine?

More recently intravenous processine has been used for the pruntus of jaundice, so for the management of burns," as a substitute for morphine in postoperative care, 11 for arthritis, 12,12 for anesthesia,14 15 and for serum sickness.15 17 This report deals with the use of intravenous processe hydrochloride\* for the control of pain in traumatic and inflammatory conditions Although "pain is only a subjective phenomenon quite imperceptible,"is it is an evil to be relieved as promptly as possible by means which will not produce pathologic changes in the human organism. The methods at the command of the phy sician and surgeon are many, but too often the relief obtained is incomplete and temporary, and the side-effects displeasing

Presented at the 141st Annual Meeting of the Medical So-ciety of the State of New York Buffalo Section on Amethesi closer May 7, 1947 Frocalses Aprinchioffed used was "Novocain, generously donated by the Department of Medical Research Winthrop Chemical Company New York City

We have followed the course of the nam syn drome treated by the intravenous infusion of procaine hydrochloride and have found much in Although some of the results obtained. especially in osteoarthritis may point to a specific therapeutic value of intravenous procaine, we feel that the number of our clinical observations is too meager to warrant any definite conclusions. One hundred and forty cases with 608 intra venous procaine infusions are here reported There have been no serious ill effects. The un toward or unpleasant reactions observed will be reported in this paper (Since the first preparation of this paper, the authors have subsequently administered over 2.000 intravenous procaine infusions without serious complications )

#### Physiology and Pathology

Inflammation is the most important of all pathologic processes. Some degree of inflammatory change is present whenever the tissues are subjected to the action of an irritant, be it physical chemical, or bacterial. There are three main phases of the inflammatory process, each with its specific duty (1) vascular changes, (2) formation of inflammatory exudate, and (3) process of repair The first phase is the most important, for on it the second and third depend

The functional control of the blood vessels, possibly including the capillaries, "-11 depends in part on nerve impulses and in part on the ef fects of hormones and other substances carried in the blood. The extreme innervation of peripheral blood vessels is said to be derived from rams from the adjacent nerves at intervals along their course 22 This anatomical finding is especially true in the segmental distribution of sympathetic fibers in the forearm from the elbow down and in the leg from the knee down,

The concept of chemical mediation of nerve impulses is based on the result of numerous experimental studies. The humoral substances liberated are believed to be present at the neuroeffector junction or near them as well as at the synaptic junctions in the autonomic ganglia and within the central nervous system <sup>22-25</sup> Further discussion on the chemical transmission of autonomic effects is beyond the scope of this paper, and one is referred to the work of Rosenblueth and Phillips<sup>26</sup> and others <sup>27-31</sup>

After any injury, reflexes immediately begin to exert their influences upon the affected area Some of the reflexes are a fundamental component of the organism's defense mechanism and contribute to the repair process Others may actually prolong disability In the great majority of cases of mjury the color changes, hyperesthesia, sensitiveness to cold, and other phenomena so frequently observed tend to disappear spontaneously with the completion of the healing But in other instances an irritative process continues 32 Impulses from a focus of peripheral irritation may set up a central disturbance, probably at spinal levels, which may persist even when all possible connections between the irritable focus and the cord have been severed 33

There are three reciprocating factors in the vicious circle of reflex sympathetic dystrophy <sup>34</sup> (1) incoming impulses from the periphery, (2) the internuncial pool activity, <sup>35</sup> (3) the "facilitation" of conductivity within the spinal cord <sup>36</sup> The elimination of the irritable focus producing the incoming impulses would not only break the circle, but in most instances eliminate pain The burning, throbbing pain found in trauma and inflammation is purely sympathetic in character <sup>18</sup>

Why the chemical or surgical section of sympathetic fibers should eliminate the pain originating from the injured sensory nerves is not clear, since sympathetic nerves in the extremities are said not to contain afferent fibers. One hypothesis of the irritable focus postulates the existence of a pathologic state of the sensory nerve fibers. Following trauma, demyelinization of sensory nerve fibers may occur. With cross stimulation occurring between the afferent sympathetic and the poorly insulated sensory axons, resulting in pain or even efferent vasocilatation as in the causalgic state or vasoconstriction in traumatic cases.

The humoral imbalance existing at an irritable focus depends upon the liberation of histamine<sup>25</sup> or histamine-like substances<sup>40</sup> from the immediately-affected cells, directly causing dilatation of the capillaries with which it comes into contact and acting as a persistent stimulus to the sensory endings of the terminal axon branchings. It is this excess of histamine or histamine-like substances, we believe, which acts on the nerve fibers to the terminal arterioles by depressing acetylcholine.

The formation of an inflammatory exudate

depends upon the gradient of permeability of the smaller blood vessels 41-44. The cause of the gradient is to be found in a structural differentiation along the capillary, such that the barrier offered by its wall progressively diminishes on the way to the venule 45. The role of hydrostatic and physicochemical forces in the formation of evudate has been adequately described by Bellis 46. The effectiveness of intravenous procaine therapy in the pathologic state is based on the permeability of the capillary membrane to colloid as well as to ions 47-54.

One can summarize and conclude from the above that the local vasospasm occurring after trauma results in capillary dilatation, incompetence, or decompensation, thereby (1) preventing normal tissue metabolism, (2) interfering with the normal interchange of tissue fluids in the region of injury with the loss of plasma, (3) resulting in the accumulation of the products of trauma, and (4) ending often in the degeneration and local death of tissue

#### Pharmacology

Procaine is para-aminobenzoldiethylaminoethanol, soluble in one part of water in which its reaction is neutral. It is stable and does not decompose at temperatures as high as 100 C. When injected intravenously in sublethal doses, two processes are initiated. (1) hydrolyzation of procaine by an enzyme into para-aminobenzoic acid and diethylaminoethanol, (2) acetylation of para-aminobenzoic acid. 55 56

Nearly 95 per cent of the injected procaine can be found in the urine<sup>55</sup> either as para-aminobenzoic acid, para-aminohippuric acid, para-aminobenzoylglycuronate and diethylaminoethanol, or even as traces of procaine <sup>57</sup> Procaine or one of its hydrolytic products, para-aminobenzoic acid, has been shown to be removed from the blood stream in twenty minutes <sup>57</sup>-<sup>59</sup>

The authors believe that in traumatized or inflamed areas procaine administered by the intravenous route has a twofold action (1) direct action on the irritated nerve fibers, (2) indirect action of diethylaminoethanol on the endothelium of blood vessels Although there is an opinion that procaine intravenously provokes direct action on endothelium, out is our opinion that one of the end products of procune, diethylaminoethanol, is the substance involved The basic structural similarity between diethylaminoethanol, benadryl, and choline must be noted (Fig 1) The mode of action, as with benadryl,61 at the capillary bed may be considered as a competition between histamine and diethylaminoethanol for a given site of action or receptive substance, or the action might be explained from the clinical observations on a

Fig. 1 Structural relationship of diothylaminoetanol benadryl and choline

cholinergic typo response. The investigation of the action of the compound diethylamino-ethanol is a subject of present study.

The toucity of procaine injected intravenously within a short period of time has been found to vary in several numal species 40 to 60 mg per Kg in the rabbit; 40 to 45 mg per Kg in the cat. 40 mg per Kg in the guinea pig; 62 4 ± 14.6 mg per Kg in the dog 4 The lethal dose in man is not known. However, it is well established that the toxicity of procaine in man is dependent upon the percentage concentration administered. Toxicity increases in a geometric ratio

In determining the desage of intravenous procame for the relief of pain, several factors had to be considered (1) the amount, (2) the con centration, (3) the rate of administration Since the death of experimental animals was contingent upon certain critical concentrations of procaine in the blood to produce a central medullary paralysis " we believed the total amount of procaine injected should be well below the average minimum lethal dose of experimental ani mals, 40 mg per Kg The next phase concerned itself with the hydrolytic products of procaine para-ammobenzoic acid and diethylammoethanol Patients could tolerate blood concentrations of para-aminobenzous acid of 30 to 60 mg per hundred cubic centimeters without ill effects The similarity between diethylaminoethanol and benadryl prompted us to accept the desage of benadryl in children," and therefore we chose the amount to be given at any one time to be 4 mg per kg body weight.

The amounts of procaine to be used were so small that in order to obtain accuracy and for increased safety the procaine was diluted to make a 0.1 per cent solution (1 1000 solution) in isotome saline. Thus 1 co. of solution contained

one mg of procaine (A 0.2 per cent solution was tried in a number of administrations but with a greater incidence of unpleasant side-offects)

Anowing that procaine injected intravenously can no longer be identified as such or as para aninobenzoic acid after twenty minutes, and that the sudden injection of large amounts of fluid would not be tolerated we concluded that the total amount of procaine and saline should be given over a twenty minute period. For this purpose we have utilized a flowrator for accurately determining dosage and for a constant uniform rate of administration.

In order to simplify our work, we devised the term "procaine unit", to the amount of procaine calculated at 4 mg per K<sub>b</sub> body weight to be given in twenty minutes in a 0.1 per cent isotonic saline solution. The error factor in using the flowrator is less than one half of 1 per cent. For example, a 70-kilo man would receive 280 mg of procaine in 280 cc. of isotonic saline in twenty minutes, or 14 cc. of isotonic saline in twenty minutes, or 14 cc. of solution per minute. In practice we have most frequently administration. On subsequent administrations the patients were given the predetermined dose

The technic we have employed in preparing the solution is as follows (1) 5 cc of a 20 per cent solution (1 Gm) of procaine hydrocalionde is added to 1000 cc. of isotonic saline (2) the resulting solution is vigorously agitated in order to insure uniform solubility of the drug, (3) the procaine solution is then administered by means of the flowrator incorporated into an ordinary intravenous infusion setup or by the infusion drip with control clamp

With the use of the flowrator administration is simplified. The drip method necessitates the counting of drops per minute and extensive experience in order to administer the drug uniformly. Because of the fairly rapid rate of flow we have employed a number 10 gage needle. A smaller gage may be used for children.

Before discussing the clinical applications, we might mention typical signs and symptoms as observed during the administration. About five to seven minutes after the start of the in fusion the patient usually describes a sensation of warmth throughout the entire body. A flush is sometimes noted over the head face, and neck, except for a marginal circumoral pallor. Soon after the onset of this flush the patient notes a dryness of the mouth, sometimes accompanied by a metallic taste tearing of the eyes dilatation of the pupils, and light-headedness. Many patients feel comfortably relaxed with the alleviation of the pain. In our administration of processing we strive not to exceed those manifesta-

TABLE 1 -- CLASSIFICATION OF CASES

				<u></u>
	Туре	Number of Cases	Number of Infusions	Results
Traun				
Ā	Fractures	28	28	Relief of pain
	Postdislocation arthralgia	5	19	Relief of pain increased mobility
- Ĉ	Sprains	6	6	Relief of pain increased mobility
ă	Traumatic arthritia	3	18	Relief of pain increased mobility
Ĩ.	Myofascitis	11	33	Relief of pain increased mobility
B C D E F	Hermated intervertebral disk	5	10	No change in pain complex
Ġ	Postoperative pain	3	-8	Relief of pain
Ħ	Reflex sympathetic dystrophy	16	44	Relief of pain increased mobility return to normal of vasomotor imbalance
I	Lacerations and contusions	2	2	Relief of pain débridement and repair of wound
Inflere	Inflammatory			
J	Rheumatoid arthritis	9	51	Temporary questionable results except in selected cases
ĸ	Osteoarthritis	21	99	Relief of pain increased mobility
Ĺ	Neuritides	6	16	Relief of pain
$\overline{\mathbf{M}}$	Vascular diseases			
	1 Thrombophlebitis	4	24	Relief of pain
	2 Arteriosclerotic gangrene	1	1	Relief of pain, preoperatively
	3 Trench foot	1	2	Relief of pain, increased mobility return to normal of vaso- motor imbalance
N	Bursitis	2	5	Relief of pain increased mobility
ő	The spine	ĩ	2	No change in pain complex
_	-	•	-	110 orange in pain complex
	llaneous		9	Only 4
P	Malignancy	2	9	Only temporary relief of pain
Q	Antenor poliomyelitis	•		D. M. C. of H. a. 1.49 a. a. a. d
	1 Vasomotor	2 2	12	Relief of "cold" sensations
	2 Spastics	<del>-</del>	12	Increased mobility decreased spasm, increased muscular co- ordination
R.	Amyotrophic lateral sclerosis	1	10	No changes
ST	Multiple sclerosis	1	. 8	No changes
T	Congenital spastics	8	200	Increased mobility decreased spasm, increased muscular coordination
		140		
Tot	ai	140	608	

tions The more severe responses to this drug, that we have noted on occasions and which we consider undesirable, are marked dizziness, apprehension, sensation of trembling, or sleepiness beyond comfortable relaxation. We have had two instances of momentary unconsciousness, but at no time has the use of sedatives, oxygen, or restorative drugs been necessary. To date, after 2,000 administrations, we have noted no cases of procaine sensitivity or any contraindication to the use of this drug.

#### Clinical Observations

The 140 cases, upon which this report is based, are classified as (1) traumatic, (2) inflammatory, (3) miscellaneous Table 1 lists the types of cases, the number of cases, the total number of infusions given in each subdivision, and the results

The results in the management of pain in trauma have been uniformly good, except for the cases of herniated intervertebral disk. In the 28 fracture cases, two were reduced without pain under this method, but the anesthesia is not all that might be desired with this technic. On the whole, postreduction pain was controlled satisfactorily with only one infusion in each case.

The low back pain syndrome due to hermated intervertebral disk does not respond to this treatment The following case is illustrative of this

Case Number 37273 —A 48-year-old white man, a clerk, had severe pain in his back with radiation

down the left leg. The presumptive diagnosis following physical examination, roentgenographic examination, and spinal fluid studies was that of herniated intervertebral disk. His weight was 60 Kg, and 240 mg of procaine were given without relief of pain. Operation two days later confirmed the presumptive diagnosis. This case is typical of the pain syndrome due to a mechanical factor. We have since accumulated 15 additional cases to the 5 mentioned above, whose response to procaine has been negligible and whose diagnoses were confirmed at operation. We are using this method for differential diagnostic and

The inflammatory cases\*\* on the whole responded well. A preliminary report on the use of intravenous procaine in the management of arthritis has been presented by the authors recently 12. The results especially in osteoarthritis were very encouraging

The following case is typical of the series

Case number 37438—A 53-year-old white woman, a housewife, complained of pain in her knees and mability to walk stairs for the past two years Her weight was 60 Kg, and she received 240 mg of procaine intravenously—Immediately following the infusion, there was no pain and no restricted mobility—The patient was able to climb and descend steps with ease—She received one subsequent infusion six weeks later—It is now four months since the second infusion, with no complaints of pain or restricted mobility

In the miscellaneous cases we found some interesting phenomena We did not expect to find

<sup>\*\*</sup> Referred from the Medical Service Reconstruction Hospital Unit by Dr Joseph Kovacs assistant attending physician.

any changes in the neurologic cases, but treated them in order to see if any improvement could be noted In 2 cases of anterior poliomyelitis, with flaccid paralysis of many years' duration, there was the following response during the infusion, the patients stated that a tingling sensation of warrath crept down the affected extremities This vasodilatation was maintained following each injection for several days and even weeks The absence of the sensation of cold and the elimination of external heat applications especially at night was very gratifying to the patients This prompted us to try processes infusions in 2 cases of spastic anterior pollomyelitis

The results were relief of spasm increased mobility, and improved muscular control From our observations, the use of intravenous procaine in alloviating muscle spasm suggests its therapeutic application in the symptom relief of the distress of acute anterior poliomyclitis.

The use of curare in conjunction with physical therapy has given some very satisfactory improvement The use of procaine intravenously, in patients who have been on curare therapy every eight hours for one month with only slight improvement and relaxation of the spasticity, responded with what might be termed a dramatic response. Procume infusions were administered to several congenital spastic patients daily for three to four weeks, and then given weekly procame infusions. All of the patients treated with procaine and physical therapy have shown marked relaxation, increased coordination marked mobility of the extremities, and use of the extremities Manipulation and stretching during the procesine infusion is attended with a minimum of discomfort to the patient

An interesting side-effect noted in the spastics is an improvement in speech and increase in mental acuity It should be mentioned that spastic upper extremitics respond slower than the congenital spastics, where the greatest involvement is in the lower extremities youngest congenital spastic treated was twentysix months

#### Summary and Conclusion

- Intravenous procaine infusion for the management of pain in trauma and inflammatory conditions is a safe hospital procedure, provided that the administration is controlled
- The indiscriminate and careless administration of procesne intravenously may prove dangerous
- Intravenous procaine should be considered

as an adjuvant to the management and treatment of selected traumatic, inflammatory, and spastic conditions.

#### Discussion

Dr Maurice Bruger, New York City -The opportunity presented itself to Dr Currence Dr Eby Miss Swanson and myself at the New York Post-Graduate Hospital to follow the variations in blood chemistry in patients receiving a procaine unit (as defined in the above paper) intravenously twice weekly Renal aspects were evaluated by the determination of the whole blood urea nitrogen nonprotein nitrogen and by urine analysis hepatic damage by the cophalin-cholesterol flocoulation test and by thymol turbidity, general metabolic alterations by whole blood sugar (true glucose) and serum cholesterol Sedimentation rates were also determined The chemical studies were carried out at weekly intervals, a total of 17 such studies being made before and during the course of procaine therapy in 5 patients No significant alter ation in any of the chemical constituents of the blood was noted. Urine analysis failed to reveal any renal irritation. It would appear safe to state at this time that proceine administered intravenously twice weekly over a period of one month in the doses indicated has no measureable effect on renal or hepatic function nor does it alter the sugar or cholosterol content of the blood or the rate of sedi mentation of the red cells.

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The authors wish to acknowledge the cooperation of the Department of Physical Therapy of the Reconstruction Hospital Unit and the New York Post-Graduate Medical School and Hospital.

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#### BILL PROVIDES HEALTH AID

Introduced in the Senate during the last session, was a bill to provide for the general welfare by enabling the several states to make more adequate provision for the health of mothers and children, for services to crippled children, and for other purposes. The bill was referred to the Committee on Labor and Public Welfare

and Public Welfare

This bill makes permanent the Emergency Maternal and Infant Care Program, authorizing an appropriation of \$20,000,000 for the fiscal year 1949, \$30,000,000 for the fiscal years 1950 and 1951, and such sums thereafter that Congress may determine necessary for the expansion of grants-in-aid to the states for maternal and child health services. Ten per cent of these annual appropriations is made available for dental services for mothers and children, and further authorizations of \$15,000,000 for 1949 and \$20,000,000 for the next two years, for the care and treatment of crippled children

The bill also establishes a Maternal and Child

Health Advisory Council to be composed of not more than 18 members appointed by the Federal Security Administrator without regard to civil service, with at least six appointed from the public, and eight from the medical, dental, and related professions. Two-thirds of the Council is to be selected from panels of names submitted by national professional or other agencies and organizations concerned with medical, dental, nursing, hospital, and other professional services related to maternal and child health and crippled children's services

An additional authorization of \$5,000,000 is included for the purpose of administration, aiding the financing of studies, demonstrations, investigations, and training of personnel for maternal and child health and crippled children's services, and to pay salaries of personnel detailed to state agencies. Authorization is made for the appropriation after the first year of such sums as may be necessary for this function

#### MEDICAL LICENSES REVOKED AND SUSPENDED

The Board of Medical Examiners of the State Education Department has announced the following revocations and suspensions to practice medicine in the State of New York

Samson Chernoff, 223 Second Avenue, New York City License suspended for a period of six months, beginning June 30, 1947

Frank E Kellner, 214 Court Street, West, Rome

License revoked, effective July 21, 1947

Herman T Leslie, 530 Park Avenue, New York City License revoked, effective July 16, 1947

Harry G Lytton, 7812 35th Street, Jackson Heights License revoked, effective July 16, 1947

John R O'Neill, 80 Cranberry Street, Brooklyn Physiotheraphy license suspended for a period of one year, beginning July 8, 1947

#### THE PROLONGED THERAPEUTIC ACTION OF INTRACAINE IN PAINFUL MUSCULOSKELETAL DISORDERS

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(From the Mount Sinat Hospital, New York City Orthopedic Department in cooperation with Dr. R. Citron from the White Plains Hospital, White Plains New York)

IN THE last few decades a number of com-pounds have been introduced for analysis and therapeutic purposes in the management of painful traumatic and orthopedic musculoskeletal conditions. The value of local and regional anesthesia to alleviate such pain has been recognized and the field of application of analgene injections is steadily expanding sistent, intractable pain accompanying certain fractures and degenerative and inflammatory processes of the joints, penarticular tissues, nerves, bursae, and muscles is frequently so severe that it disables the patient completely Disuse atrophy in long mactive joints and muscles is a common tendency Mobilization of articular and other structures can often be induced by giving a suitable, local anesthetic injection, which then permits other indicated therapeutic procedures. Although frequently only of transient effect, the employment of a suitable anesthetic agent and a correct technic may, in many in stances provide sufficiently long relaxation for the acute pathology to subside and in this way actually bring permanent relief In addition it is believed that only solutions of an anesthetic may have a prolonged anesthetic value at gliding fascial, muscular, and articular surfaces

Comprehensive studies on the therapeutic use of anesthetic agents have been made by Stein brocker, Outland and Hanlon, Wertheim and Rovenstine and Pitkin 11 Steinbrocker presented an extensive review of previous work published here and abroad on local and regional analysis injections and discussed in detail indications, technic routes and efficiency of such treatment. His own results were very promising and invited further studies Employing mostly aqueous solu tions of the anesthotic in ordinary painful conditions, he recommended an oily vehicle for slow absorption where prolonged action is required He also expressed hope for a local anesthetic hav ing the advantages of prolonged analgesia and of low toxicity

Since 1930 the author has studied various substances for their antispasmodic and analgesic effect (todipin, psicaine and eucupine) and in particular their toxicity and prolonged action Although successful in obtaining the latter, attempts to use the agents on a larger scale had to be abandoned on account of late painful tussue reactions. During the last five years he used

intracaine\* (betadiethylaminoethyl p-ethoxy benzoate) a new anesthetic agont, which was found to possess prolonged and superior anesthetic potency with almost complete absence of local toxicity \*-\* The cases presented below are the results of experience with 180 patients treated for a variety of orthopedic conditions and are in tended to illustrate the effectiveness of the intra-caino treatment and the lack of toxic reactions

#### Mechanism of Action

The large part played by vasomotor impulses in the occurrence and intensity of pain and the value of local infiltrations and nerve block in sotting up a regimen of active vasodilatation in a given area has been aptly demonstrated in the classic work of Lenche 10 The rich nerve supply in the supportive tissues of the human body especially in the ligaments in the region of an articu lation, is irritated by trauma or other pathology and a disturbed vasometer functional state characterized clinically by muscle spasm, loss of motion, pain, and tenderness prevails Analgesic injections reduce the local irritability and, by climinating the centripetally traveling pain im pulses from the traumatized area, cause a return of the vasomotor tone to normal brang about a permanent cure in certain conditions and in others control the discomfort until other established measures of thempy achieve their effect

#### Toxicity of Anesthetic Agent

Preliminary experiments were carried out in animals to confirm previously made observations on the low toxicity of the anesthetic agent. These tests were done as follows. 0.2 cc of a 5 per cent intracaine in oil solution was injected by means of a 22 gage needle into the right erector spinao muscle (½, inch deep) and in knee joints of rabbits after hair removal and sterilization. The injection produced immediate anesthesa as tested by needle prick but no other reaction such as swelling or increase in skin temperature over the injected area was noted and the animals lost no weight during the three weeks of experimentation. Injections were made into the muscle on the second, ninth, sixteenth, and twenty first day, and

<sup>\*</sup> Supplied through the courtesy of E. R. Squibb and Sons New York.



Fig 1 Injecticaine in oil into er hours later

into the knee joir days. On the tw killed by intraven examination of n show any inflamm normal color, and ance with interspe examination reve seen in Figs. 1, 2, a

Fig 1 shows th jection into the septa throughout by edema charac precipitated prote network. The mu exhibit a moderate Large mononuclea mulated in an occ a few extravasated





Fig 2 Nineteen days

TABIE 1

		111	31 12 1				
Number of		Type of Injection	Dosage, Cc	Number of In- jections	Cases	Result	
Cases	Diagnosis  Low back pain	Intramuscular	2-5 2-3	2-3	25 12	No complaints Greatly improved (c=-) therapy)	
40	Sacrolumbar — sac rolliac sprains and spinal derangements	Paravertebral Epidural	10	3	3	\o improvement	
29	Fractures	Periosteal	2.4	1	26	No complaints (cent. 15. aps) Greatly improved	
		Intramedullary		2.2	1	No improvement	
18	Bursitis	Pericapsular Intrabursal Suprascapular	1 3	2-3	6	No complaints Greatly improved (sche therapy)	
11	Arthritis	Pencapsular	2-6	2	7	No complaints (milest t	
9	Nontraumatic Traumatic	Intra articular Pencapsular	2-3	1 2	8	Temporary importer No complaints (continuency) No improvement	
13	Contusion Muscle tear	Subfascial	2-5	1-3	9 4	No complaints Temporary impreview bined therapy)	
5	Supraspinatus tear	Intramuscular Suprascapular	1-2	2	1 3 1	No compliats Greatly improval (entrapy) No improvement	
11	Neuntis	Perineural Epidural	2~5 10	1 2	5 U	No complaints Greatly improved (relatively)	
13	Myofascial pain	Subfascial	2-5	1	8	No complaints Greatly Improved (	
10		Edottisvia		2	1	Temporary improveses	
9	Ligamentous tears	Intraligamentous	0 5-2	1 1	6 1 1	No complaints Greatly improved (with therapy) Temporary in, review	
11	Periostitis  Epicondylitis	Periosteal	0 5-2	2 2 2	8 2	No complaints Greatly improved therapy) No improvement (next)	
10	Contractures	Intramuscular	3-5	2 3 1	5	Very much improved Improved (combaction No improvement	
2	Tendovaginitis	Peritendinous	1	1	2	No complaints	

manipulated during the first visit after intracaine injection the results were much better than in 6 similar cases manipulated without intracaine No untoward reactions in any case were observed.

Fractures—The advantage of a prolonged anesthesia was very striking in such fractures not requiring strict immobilization and where the ensuing, prolonged painlessness allowed early function.

The following types of fractures were treated 4 rib, 2 transverse processes, 5 os coccyx, 1 ulnar styloid, 3 hip, 4 ankle (fibula), 3 wrist (radius), 3 metacarpals, 3 metatarsals, and 2 collarbone All cases were characterized by severe localized pain and general absence of gross displacement, or marked swelling

Treatment—Only one injection of intracaine was necessary in 23 cases and a second injection after a few days in 2 coccyx fractures Eight

patients were treated after the methal, strapping (rib, transverse proces, etrap bone), and one requiring a body cat lit verse processes) The 3 hup fracture [ or abduction type), and the 3 os coeffit were given the injection in combinate Eleven fractures (ankle, with carpal, and metatarsal) received plasted immobilization in the routine manner were immediately relieved of pain dara. reduction and initial fixation and week benefited by intracaine ointment massel removal of the immobilization One state ture with marked soft tissue swelling outer ankle experienced more pain that after the injection, this was apparently the marked edema which is a control of No untoward were observed in the whole group became painless faster and longer that tic one hour after the injection while the zones over the intracalne injection showed no sign of irritation

In the clinical studies presented below, intracaine was used in amounts ranging from 0.2 to 25 cc. without any untoward reaction. The apparent lack of toxicity of intracaine observed by other workers\*-\* in many thousands of cases, where as much as 50 cc. were used without one single untoward reaction, could be confirmed in these studies.

## Technic and Dosage

The technic follows the general rules of any local anesthetic for regional conduction or segmental anesthesia. Intracaine in oil was avail able m a 2 per cent and a 5 per cent concentration The 5 per cent concentration was preferred in the majority of cases on account of markedly prolonged anesthetic action For surface anesthesia in form of massage a 1 per cent aqueous solution of diethoxin (intracaine base) was employed Intracame in oil was administered by the intramuscular, subfascial periarticular, intraligamentous, penneural, penosteal, paravertebral, and epidural routes The amounts used varied from 0.5 cc. to 25 cc. with an average dose of 3 to 5 cc. which, in some cases, was repeated every day up to ax times during a period of three to four weeks A 22 gage needle was used after aspirating the intracaine with a 19 gage needle

Intracaine in oil was also given by the intraarticular route with the aim of producing an artificial effusion and to cover the damaged cartalage of the arthrite joints with a lubricant, having gradually discharging anesthetic properties. This method had to be abandoned because of undue reactions in form of pain, effusion, and lack of permanent benefit. The periarticular route was used instead with good results since the pain, according to Lenche, does not arise from the cartilage devoid of nerve supply but from the periosteum, the joint capsule, and periarticular structures.

When administering intracaine in oil, it is important to inject the preparation below the subcutaneous layer by deep intramuscular administration as, otherwise, a painful itch may develop In sensitive patients and for paravertebral or epidural block first 15 to 5 cc of aqueous intracaine were used, aspirated in the same syringe with the oily intracaine which collects above the aqueous solution near the plunger when the syringe is kept with the needle downwards. A 'fan-wise" distribution in horizontal oblique, and vertical direction insures the best results and serves to avoid pooling in one tissue level, except in cases treated by conduction anosthesia.

### Clinical Studies

The type and number of cases treated with in tracaine and an evaluation of the effectiveness of intracaine therapy are presented in Table 1

 $L_{ow}$ RackPan-Sacrolumbar-Sacroluae Sprains and Derangements -Since it is very dif ficult and often impossible to differentiate the exact pathology in the absence of positive \(\tau\) ray findings we use the term sacrolumbar and sacroiline topographically for the largest group charactenged by "low back pain" It consisted of 27 men and 13 women The onset of pain was sud den in almost every case and appeared to be brought on by an unguarded motion carried out while standing or sitting Twelve patients of the sacrolumbar and five of the sacrolliac group had sustained similar attacks previously with a dura tion of pain from two days to three months The symptoms were localized burning, deepseated stabbing sensation or diffuse pain across the back, sometimes of an agonizing character, and pain travelling in the groins or down the posterior leg portion which was aggravated by sneez ing and coughing When pain was diffuse and no localized tender areas could be elicited, a paravertebral block was done according to the tech nic of Pitkin.11

Treatment -All patients after the intracame injection were strapped, advised to sleep on a fracture board with a pillow under the knees to keep them flexed In a few cases, use of local, moist heat and analgesics was required sacrolumbar type 15 cases were relieved of their pain by one injection, 6 were greatly improved but required a second and third injection after forty-eight to seventy two hours in combination with traction, physiotherapy and spinal brace Two cases had to be hospitalized on account of severe pain but improved immediately after in jection of 4 cc. of intracaine in oil in combination with 1.5 cc. curare Two patients with pri mary disk symptoms showed no improvement with intracaine and had to undergo surgical pro-No untoward effects were noted ex cedures cept short. Insting drowsiness in one patient who had been given curare.

Ten of the sacrollac type were greatly improved by one injection of intracaine, two received 2 and 3 injections, respectively. Combined treatment (manipulation, traction, brace, physichlerapy), and prolonged hospitalization were required in 4 cases. One case with no improvement turned out to be a protruded disk between LV and SI and was treated by neurosurgery. Two cases with repeated injections showed sparalization and facet anomalies. Of 6 cases

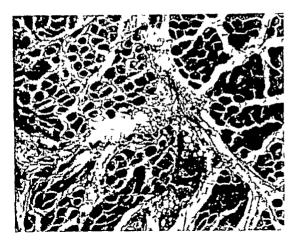


Fig 1 Injection of 0.2 cc of 5 per cent intracame in oil into erector spinae muscle of rabbit, 24 hours later

into the knee joint on the second and sixteenth days. On the twenty-third day the animals were killed by intravenous air injection. Macroscopic examination of muscles and knee joints failed to show any inflammation, the muscle fibers showing normal color, and the cartilage a smooth appearance with interspersed oil droplets. Microscopic examination revealed the histologic picture as seen in Figs. 1, 2, and 3.\*\*

Fig 1 shows that twenty-four hours after injection into the muscle the connective tissue septa throughout the musculature are widened by edema characterized by an abundance of precipitated protein and a well-developed fibrin network. The muscle cells adjacent to the septa exhibit a moderate degree of intracellular edema Large mononuclear wandering cells have accumulated in an occasional septum and there are a few extravasated erythrocytes

\*\* The histologic examinations were kindly carried out by Dr Homer Kesten pathologist White Plains Hospital

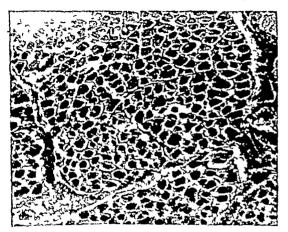


Fig 2 Nineteen days after injection into erector spinae

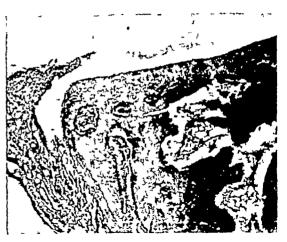


Fig 3 Injection of 0.5 cc of 5 per cent intracaine in oil into knee joint of rabbit, 19 days later

Fig 2, nineteen days after injection, revealed the muscle bundles are spread apart by a quantity of edema fluid containing precipitated protein and a delicate network of fibrin. This tended to extend around individual muscle cells little recent hemorrhage is associated with it Most of the muscle fibers are unaltered save for an occasional swollen, partly vacuolated element At one point several muscle cells have been destroyed (artefact?) and the surrounding and adjacent connective tissue is infiltrated by small numbers of large mononuclear wandering cells, together with polymorphonuclears, and occasional lymphocytes Proliferation of muscle cell nuclei has taken place in a few of the remaining fibers about a focus of infiltration

Fig 3 shows that nineteen days after injection into the knee joint the periarticular tissues are free of inflammatory reaction. The joint space is empty. The joint capsule and the articular surfaces are smooth without evidence of degeneration or inflammation.

The author carried out tests on himself in order to make a comparison between the effect of procame in oil (5 per cent) and intracame in oil (5 per cent) Some difficulty was experienced in completely dissolving the procaine crystals in almond oil The volar side of the left lower arm was injected intradermally with 0 1 cc each of the two substances forming wheals of 1/2 inch diameter and tested by needle prick as to the anesthetic effect after one, two, three, and four hours While the procaine effect subsided after less than two hours, the intracaine effect was still present after four hours in the form of anesthetic spots over the wheal area and an area of anesthesia along the ramus superficialis of the radial nerve, slight but quickly subsiding itching was noticeable after six hours The procaine wheals became hyperesthegroups treated with novocaine. This was especially striking in the rib transverse process and coccyx fractures.

Burntus -This group represents 14 cases of subdeltoid bursitis type (four complicated by penarticular fibrosis), 2 cases with local tenderness over the subacromial region one with the trigger point over the corncoid region, 3 cases of burnitis subtrochantene and one infrapatellar Srx individuals had suffered previous similar attacks lasting from one to fourteen days The symptoms were pain around the affected area with sharply defined trigger points, muscle spasms, various degrees of joint fixation up to complete limitation and pain travelling down the upper arm. No definite pathologic anatomic diagnosis could be made, but fluorescopy showed the presence of calcareous deposits with small deposits in eleven subjects causing usually more pain than large ones The patients with shoulder involvement felt particularly uncomfortable generally

Treatment -All cases after injection of 1 to 3 cc. intracaine were gently manipulated in all planes to insure thorough oil distribution. The shoulder patients were advised to wear a sling for twelve hours, the others to stay off their feet for one day In the presence of deposits thorough needling was done. Additional routine therapy consisted of application of icebags, phenaphen or demerol medication. Of the 14 shoulder cases, 8 were greatly improved by one intracaine injection, 6 showed improvement but needed repeated injections with smaller amounts after forty-eight and seventy two hours, and other therapy The 2 trochanteric burnitis cases required one injection only as well as the infrapatellar and subcoracoid bursitis. In those cases where presence of calcium could be demonstrated under ethylchloride spray 1/2 to 1 cc. of intracaine was injected into or around the tender area. with the needle in place the syringe removed, a thorough needling in all directions was done followed by another injection of 1/2 to 1 cc. intracame underneath and around the calcium de-In some cases the pain recurred after four to ax hours but wore off during the following ax hours One case of frozen shoulder, while under anesthesia, was administered 5 cc. of intracaine beneath the capsule and subdeltoid space followed by gentle breaking up of the adhesions. No toxic effects were noted in this group Lately we have used the suprascapular approach,11 with encour

Arthrits.—Of twenty arthritis cases ranging from 21 to 63 years of age, twelve were of the non inflammatory, degenerative hypertrophic type and eight of traumatic origin. While the first group gave a history of affliction of months and

aging results

years the traumatic arthritis had persisted only a few days or weeks. Nontraumatic arthritis in cluded the following types ankylesing spondylearthritis, malum come hypertrophic arthritis of the knees, and arthritis of the big toe joint. Traumatic arthritis involved the knee wrist, foot in combination with synovitis and capsular ligamentous tears. Symptoms in both groups were pain and limitation of joint motion. Arthritic changes were demonstrated in the form of diminished joint space, selerosing joint borders spurring fraying, decalcification. The blood count and sedimentation rate were found normal.

Treatment -Intracaine (2 or 5 per cent solu tion) was used in amounts of 2 to 6 cc depending upon the size of the area. In ankylosing spondyhtis the painful muscle spasm with involvement around the facets or the intervertebral junctions was greatly relieved after injections twice weekly for a period of three to six weeks. The resulting disappearance of tightness allowed easier appli cation of other physic- and orthopedic procedures. The same degree of improvement was experienced in the cases of malum covae where periarticular injection of 3 to 5 cc of intracaine by ilio-inquinal or supratrochantene approach produced considerable relief of pain and lessening of the flexion-adduction contracture for twelve hours lasting up to one week.

During the painless period physiotherapy, manipulation, casts, or braces were applied without discomfort. Two cases did well for four months without any additional therapy. Of the nine cases of knee arthritis, the six of traumatic origin were relieved of pain and muscle speam after one or two periarticular injections of 2 to 3 cc intracaine the others requiring additional in jections and physiotherapy or temporary cast immobilitization.

Three patients with involvement of smaller joints were free of pain after one injection of 1 cc. In two cases the intra-articular injection of intracaine into the knee caused increasing pain and effusion. Although no other reactions ocured and histologic findings in animal experiments failed to show signs of synovial irritation or cartilaginous damage it is felt that intra articular injections should be restricted to small joints and using only a few drops of intracaine.

Confusions—Muscle tears—In this group there were 13 patients, all with a history of a sudden twist or bend with severe local pain, muscle spasm, and different degrees of disability. They were first sprayed with ethylchloride and then impected with 1 to 3 cc. of intracaine in oil (sometimes preceded by an aqueous solution of intracaine) deep intramuscularly at the most tender area, followed by tight strapping and rest with recompresses for twelve hours. Nine patients did

not require any further treatment, three required longer bed rest and repeated injections, and one wore an Unna boot for four weeks

Supraspinatus tear—Five cases of partial supraspinatus tears occurred suddenly after lifting, causing shoulder pain which varied from sharp localized constant pain over the supraspinatus insertion to occasional attacks persisting for many months and aggravated by lifting the outstretched arm between an abduction angle from 20 to 70 degrees. There was, in the older cases, atrophy of the upper shoulder girdle and diminished muscle power. Two cases had been treated with physiotherapy for many months without noticeable relief.

Treatment —An injection of 1 to 2 cc intracaine was given over the posterior-lateral aspect of the musculotendinous cuff by directing the needle along the supraspinatus course toward the greater tubercle. All patients were advised to avoid abduction movements. In three cases the severe pain subsided with some pain on heavy lifting. One patient was completely relieved after two injections at four days interval, one patient showed relief for more than six hours but experienced increased pain necessitating immobilization in shoulder spica for four weeks.

Neurous —Because of the difficulty to establish a definite pathologic diagnosis, all patients with pain along the root or course of nerves and absence of other signs were labeled as having neu-Most of them gave a vague history with insidious onset of varying intensity lasting for weeks or months of burning or stabbing character There was tenderness along the nerve distribution with zones of hyper- or hypo-esthesia In several instances the pain was of symptomatic nature with underlying primary pathology later diagnosed as protruded disk, scalenus syndrome, amputation neuroma, or arthritic changes, one of which was found to be a spreading metastasis of an hypernephroma, one was a myeloma clinically impressing as intercostal neuralgia

There was a brachial neuritis in a menopausal overweight patient, one of the meralgia paresthetica type, two genuine sciatica, and seven symptomatic neuritis. In all cases complete medical and x-ray examination was carried out, including blood count chemistry and internal examination, before the diagnosis of a genuine neuritis was established.

Treatment — Intracaine injections varied between 2 and 20 cc in combination with 5 cc of the aqueous solution in doses above 10 cc of the oily solution. The high doses of 20 cc were used for epidural anesthesia in the 2 cases of sciatica, in another case 10 cc were used for injection around an amputation neuroma. Satisfactory results were obtained in one case of neuralgia.

paresthetica, one case of brachial neuritis, in the amputation neuritic patient, and in 2 sciatic cases, while the two sciatic cases due to protruded disk and the other types of neuritis obtained temporary relief only. This group has to be considered the most unfavorable as far as complete relief from pain is concerned.

Myofascial Pain — The thirteen cases which had to be labeled as myofascitis exhibited localized or radiating pain of different degree with limitation of motion due to muscle spasm and a duration of between a few hours and a few days Pain appeared either gradually or suddenly and, in most cases, no reason could be advanced for its appearance. In four cases the cervical region (occipital and upper trapezius) was affected, in six the back (mostly between the shoulder blades or in the iliolumbar area), in two the trochanter region along the tensor fasciae, and one patient presented myofascial symptoms over the upper calf

Treatment —A dose of from 2 to 5 cc intracaine in oil was injected "fanlike" into the tender area beneath the fascia and deep muscle layers. In place of strapping, frequent hot baths, with subsequent perspiration, and high doses of salicylates were advised. Of this group 8 individuals had immediate and lasting relief after one injection, 4 were very much improved in combination with physiotherapy, and one obtained short, lasting relief. There were no untoward reactions.

Epicondyltis—Periostitis—Of the eleven cases of epicondyltis and periostitis, five were due to acute and four to chronic trauma, and two developed spontaneously. The symptoms varied from slight pain, increasing on certain motions to constant aching, local tenderness, increased skin temperature, swelling, and limitation of motion with soft tissue shadow or periosteal thickening visible in the x-rays. Pain lasted from two days to two months. Four cases affected the medial humerus epicondyle, two the lateral, one the lateral midulnar region, two the midtibial ridge, and two the inner femoral epicondyle.

Treatment—Intracaine in oil, 1/2 to 11/2 cc, was injected into the painful area toward the periosteum, in very painful instances complete immobilization and icebags were advised for twenty-four hours. In one case the injections were repeated three times. Eight patients were cured after one or two injections, two markedly improved continuing with physiotherapy, and one showed only temporary improvement requiring radiotherapy. No unfavorable reactions were noted

Legamentous Injuries —The rather small number of patients is accounted for by the fact that we considered for intracaine treatment only those cases showing absence of marked, soft tissue

swelling over a large area, the presence of which is a contraindication for this kind of therapy. The cases treated experienced sudden onset of pain after turning an ankle or twisting a wrist Four involved the knee region (collateral tibial or fibular ligament), four the ankle (medial and lateral), and one the wrist.

Treatment —Only small amounts of intracaine (0 4 to 2 cc.) were injected deep into or under the ligamentous area in "fanlike' fashion followed by normal activity of the patient. Six patients obtained complete relief after the first injection one showed improvement which was followed by strapping and physiotherapy, and two required immobilitation (east)

Contractures — This group is of special interest since we noticed considerable improvement after intracaine injections which were in several instances, combined with curare (intocostrin-Squibb) administration. Three cases of recent poliomyelitis, one with marked pectoralis contracture and two with hamstring spasm, showed relief of muscle spasm for ten to twenty four hours following an injection of 2 to 3 cc intra caine in oil The same, or even longer relaxation, was observed after a second and third injection. Painless, passive motions and more favorable positions of the extremities involved became possible In two of these cases the intracaine injection was supplemented by intocostrin (1 co every third day)

Four cases of cerebral palsy, with flection-pronation contracture of the arm and equinus deformity of the foot of three months to three years' duration, were given repeated intracaine injections (one to two times weekly for four weeks). A dose of 2 to 3 cc was injected into the pronator group and the same amount into the calf muscles. This injection resulted in immediate, marked relief of the muscle spasm and increased range of motion. The slurring gait was improved the patients were better able to undergo passive manipulations and fixation in splints was maintained without difficulties. In two cases we combined intracaine with intocostrin producing an apparently prolonged effect.

Three cases of Little's disease with marked adductor spasm also showed considerable relief of spasm after injection of 1½ to 2½ oc of intracaine in oil into the adductor group. These petients were children between 0 and 11 years of age. Following the injection, the adduction contractures duminished immediately. The angle of abduction could be increased 10 to 20 degrees on manipulation, and hydro- or physiotherapy which followed gave more favorable results than without the injection. The relief lasted from six hours to two days in two cases and was observed again

after a second and third injection. The third child, a very emotional patient who objected strongly to the injection obtained no improve-

In general all these three groups showed diminution of the local contractures and allowed more effective physiotherapy or manipulation. The therapeutic effect could be enhanced and was prolonged by administering simultaneously curare. No complications were noted with intracaine therapy.

Tendorogrants.—Two cases of tendovaginitis were of the stenosing type (Quervain) along the flexor pollicis tendon, one with signs of locking Both were completely relieved after one injection of 1 cc, intracame into the tendon sheath.

## Summary

- 1 Intracane in oil is an effective anesthetic with prolonged analgesic action. It is an ideal therapeutic agent for certain painful conditions of the musculoskeletal system and provides for combination with other therapeutic procedures. It gives encouraging results for the relief of muscle spasm of cerebral palsy and poliomyelitis, sometimes in combination with curare.
- 2 Although the exact mechanism of lasting therapeutre analges in not definitely known analgesic injections are believed to restore a normal vasomotor equilibrium by eliminating pain impulses, musculoskeletal pain in great part assumed to be due to vasospasm. The presence of an intracellular edema persisting throughout musculature and connective tissue for a long time seems to be an important contributing factor in the prolonged intracame anesthosia.
- 3 Intracaine in oil (5 per cent) was used in 180 patients with orthopedic and traumatic disorders. It was found especially valuable in the treatment of low back pain due to sacrolumbar and sacroliac derangements in fractures bur sits, contusions, muscle tears, myofascitis, epi condylitis periostitis, certain ligamentous injuries, tendovaginits and also in contractures of spastic or mechanical origin. It also benefited cases of degenerative arthritis and neuritis.

Of all cases treated with intracaine in oil, about 50 per cent were permanently free of pain and about 40 per cent were able to receive other therapy (physic-manipulation traction casts, braces) while the acute and predominant pain was controlled by the anesthetic agent. Ten per cent were not improved

 Intracame ointment was successfully applied for massage of painful muscles after injury and immobilization in casts.

It was used with equally beneficial results in

painful skin wounds and in burns producing a prolonged and comfortable analgesic effect

Intracaine is well-tolerated in man and the absence of toxicity demonstrated by other investigators could be confirmed in these studies

> 38 South Broadway. WHITE PLAINS, NY

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## RESULTS OF SLEEPLESSNESS

Going for five days and nights without sleep can make a healthy young man "see things," laugh and talk orazily, and show other symptoms of the serious

mental disease, schizophrenia

But one night's sleep restores the voluntary victim of sleeplessness, or insomnia, to normal, Dr David B Tyler of the Army Chemical Center's Medical Division at Edgewood, Md, Arsenal reported at the American Medical Association's centennial meeting in Atlantic City

Hundreds of soldiers, marines, and conscientious objectors took part in the studies, made to learn how long men in combat could stay awake and remain

efficient fighters

Better understanding of mental disease may come

from clues furnished by the study

"We feel there is a relation between the mechanism in the brain that produces changes as a result of sleeplessness and the mechanism that produces

the disturbances in schizophrenia," Dr Tyler said
All the changes produced by the five days and
mights without sleep were confined to the brain They showed up after about thirty-six hours of sleeplessness Seeing double, hallucinations, irritability, unreasonable laughter and irrelevant conversation, memory deterioration, and remarks made as if the men were in a dream state were the signs of mental change

Brain-wave records also showed the effects of

the long time without sleep

Heart rate, blood pressure, body temperature, visual ability, and capacity to do physical work were not impaired by the prolonged period without sleep The men actually gained weight, but this was because they were given a fourth meal at midnight

Reaction time and steadiness were just as good on short tests, but fell off when the tests were pro-longed Benzedrine, familiarly known as "pep longed pills," prevented the deterioration in performance when it was given after the second day If given from the start of the five-day sleepless period, it was Its action came through its ability not effective to help the men stay awake while performing the tasks.—Science News Letter, June 21, 1947

## SURVEY MEDICAL EDUCATION

Plans are now underway to make the comprehensive survey of medical education recently authorized by the AMA Board of Trustees The AMA Council on Medical Education and Hospitals will be joined in the survey by the Association of American Medical Colleges The A.M A. council and the executive council of the college association already have discussed plans for the survey at a joint meeting, and a temporary planning committee, consisting of three representatives of each group, has been appointed

The AMA council is being represented by Drs H G Weiskotten, Syracuse, NY, Victor Johnson, Rochester, Minn, and Donald G Anderson, Chicago The college association representatives are Drs A C Bachmeyer, Chicago, Joseph C Hinsey, New York, and Walter A. Bloedorn, Washington

In view of the recent advances in medical knowledge and the nature of medical care, a careful reevaluation of the curriculum of the various medical schools is planned.

## TOWN HALL ANNOUNCEMENT

Town Hall of New York City will present six of the nation's outstanding psychiatrists in a series of lectures on "Modern Psychiatry" beginning Monday, October 20, at 5 30 in the Town Hall auditorium, 123 West 43rd Street

Among the participants from New York will be Dr Carl Binger, associate professor of clinical psychiatry, Cornell Medical College, and editor of the Psychoanalytical Quarterly, and Dr Thomas A. C. Renme, attending psychiatrist, New York Hospital, and associate professor of psychiatry, Cornell University Medical College

Dr Binger will speak on "What is Mental Health?"

and Dr Rennie, on "What is Psychotherapy?"

## MEDICAL CONSIDERATION OF THE AIR TRAVELER

FREDERICK HOPKING SHILLITO, M.D., New York, New York

INDUSTRIAL physicians irrespective of the nature of the employee group for whose health they are responsible, must be sufficiently informed on flight conditions so that they can answer the question presented by the individual, "Can I fly?"1 It has proved feasible and economic for industry to transport large groups by air, particularly when an emergency demands teams of especially trained technicians at some trouble point. In addition, executives and business men frequently use airline facilities for travel It is unusual for a company not to have some individuals who fly occasionally When concerned about some acute or chronic ailment, these persons will consult first their own company physician about the ad visability of a contemplated flight The mind of the employee can often be relieved by direct answers to questions

The physician's sound and sensible judgment is sufficient to decide most of these cases. It is not necessary that the industrial physician be a specially trained flight surgeon—Usually the important decision is whether or not the patient is able to stand the trails and vicisatudes of any kind of transportation—the mere fact that the proposed mode is a commercial airliner is not of special agnificance. Important strides have been made in improving flight conditions for the passanger, and physiologic strain has been minimized greatly. In comparison with earlier days, now all but an extremely small fraction of the population can be totally unconcerned about any possible health hazards of air travel

Airlines are now in the process of procuring larger and faster planes which will cruise at higher altitudes To the physician who is considering whether or not his patient can fly safely, it is important to realise that these new planes have the benefit of "pressurrection" The industrial physician should understand the principle of this device. To state it succinctly, in 'pressurization" outside air is compressed and pumped into the sealed passenger cabin, thereby increasing passenger comfort Actually the passenger will not even realize that his plane is pressurized unless he is told so The important point is that the passenger is not forced to accommodate to the outside or ambient pressure, since a normal atmosphere is created for him For instance, when a plane is flying at 18 000 feet, atmospheric pressure is 7.34 pounds per square inch. In a cabin built to withstand 7 pounds pressure, sea level conditions can be maintained even if the plane is flying at 18,000 feet, with 3 pounds pressurization, the cabin pressure would be approximately that of 9,000 feet instead of 18 000 feet.

In addition to pressurization, which is probably the most important step in passenger comfort which has ever been taken by the airlines, improvements have been made in accomplishing amoother flight by the use of heavier equipment, sound proofing of passenger cabins, the serving of palatable and hot meals more comfortable seats, and many other matters. All extreme strains and dangerous flight situations are meticulously avoided. In war, certain missions were undertaken and accomplished in spite of the risks. Commercial airlines, of course, are striving to their utmost to maintain schedules but will not do so if the safety of any passenger or crew member is placed in jeopardy.

Airplane flights for the normal healthy man, woman, or child can be approved by the industrial physician without the slightest hesitation True such individuals undertaking their first flights sometimes will be apprehensive Service can be rendered these persons by reassuring them of the safety of air travel In this regard, the fact can be mentioned that the airplanes have amassed hundreds of millions of passenger miles and that this mode of travel is well established as a public service. It is no longer in the experi mental stage More specific problems for the industrial physician come up when he is asked "Can I fly?" by employees who are suffering from some specific acute or chronic disease or who have some physical disabilities

## Specific Problems

Sinuses and Ears.—The presence of perforation of the ear drum is no contraindication to passenger air travel A recently healed perforation might be reopened if equalization of pressure through the eustachian tube is not watched carefully Infected sinuses are often emptied during ascent but the narrow ostia may close during descent. This event will cause pain over the affected sinus or in the teeth (aerodontalgia) Any individual with chronic infection in the sinuses should be provided with nasoconstrictor nose drops or inhalors to use in the nostrils before descent.

Acute upper respiratory infections (especially in the early stages when congestion is a promin ent feature) are a cause of swelling at the orifices

Presented at the 141st Annual Meeting of the Medical Society of the State of New York, Buffalo Section on Industrial Medicine May 8, 1947

of the eustachian tubes. This condition may block the equalization between the middle ear and ambient pressure. Nasoconstrictor drugs should be used periodically, both before ascents as well as before descents, in order to keep the eustachian tubes fully patent. Distortion of the drum produces aero-otitis. This condition clears spontaneously—although many flight surgeons advocate politzerization or the Valsalva maneuver as soon as the condition is apparent.

Cardiac Conditions—The etiologic and anatomic diagnosis is less important in contemplation of a trip by plane than is an appraisal of cardiac reserve—Sitting quietly in a seat in a plane at altitudes usually flown is no more strenuous for the patient than moderate exertion on the ground

The ambulatory cardiac will not usually be embarrassed in any way by a flight. In anginal failure, it must be remembered that the usual travel details of carrying bags or hurrying for connections at terminals may impose sudden strain and produce anginal pain. Patients with low cardiac reserve who are unable to walk short distances without inducing congestive failure should not be exposed even to the relatively slight strain of 8,000 feet altitude. Such patients can travel by air if oxygen is administered, but this is a therapeutic problem and is not met by the presence on the plane of oxygen furnished for emergency use

Anemia —Persons with a moderate degree of anemia are able to tolerate the usual cabin pressures without difficulty Individuals with marked anemias, with red blood cell counts below 2.5 million, will experience tissue anoxia at even relatively low altitude. Such persons should be transfused to satisfactory levels of red cells before traveling.

Pulmonary Conditions —Conditions which lower pulmonary function, such as diffuse fibrosis, must be evaluated in terms of respiratory reserve Little difficulty in such air travel will be experienced except in cases where even moderate exertion at sea level causes marked dyspinea. The person with asthma is a problem when an acute attack is precipitated while aloft. Oxygen should be available to be used in such an emergency. The clean and slightly rarefied air of the airliner cabin, however, is not especially apt to precipitate an attack.

The physician should bear in mind that there is great danger for the pneumothorax patient in flying. At 10,000 feet altitude, the volume of air increases nearly one and one half. Serious, even fatal, accidents can result due to shifting of the mediastinum or tearing of adhesions. Releasing pressure in a pneumothorax by aspiration could be employed by a physician in order to prepare a

patient to fly, but even this procedure is not altogether safe as there may be areas of incapsulated gas in pockets which do not communicate with the main pneumothorax

Dowds has reported a fatality occurring in an airline passenger which resulted from overexpansion of a pneumothorax due to decreased barometric pressure during flight The accident occurred due to the fact that the patient apparently was unaware of the danger Suffering from tuberculosis, pneumothorax therapy was instituted in 1943 with a 200-cc refill on March 28, 1945 At 2.05 A.M March 31. he boarded a plane An altitude of 11,000 feet was reached without discomfort At 16,000 feet, he became cyanosed and dyspneic, and unconsciousness supervened During descent, cyanosis cleared at 5,000 feet He was removed to a hospital where coma and convulsions continued until his death At autopsy, the right lung was found half collapsed and the brain was edematous In this case, air emboli or cerebral anovia may have been the cause of death as obvious damage to the thoracic organs could not be demonstrated

Pregnancy —Any woman in the pregnant state, of course, is liable to spontaneous abortion, miscarriage, or premature delivery for a variety of causes. There is nothing inherent in the pregnant state which specifically contraindicates air travel at moderate altitudes. Until the last month of a normal pregnancy a woman is usually permitted to travel by air without question. During the last month, no air trip should be undertaken without an examination by the attending obstetrician, who should approve the trip in all details

Recently, on a transocean plane, a stewardess was informed by a pregnant passenger that labor pains were commencing Rupture of the membranes occurred spontaneously and prematurely sibly this event delayed the progress of labor plane was two hours from the nearest port lowing instructions given during her training course, the stewardess arranged for the patient to lie down Any possibility of contaminating the perineum was avoided by meticulously avoiding any manual examination of the perineum Labor pains in creased in frequency until they were timed at fiveminute intervals and preparations were made to attend the delivery A landing of the plane was made, however, and the patient was placed in a hospital under the care of a physician Delivery of twins occurred about eight hours after admission to the hospital

Motion Sickness —The incidence of thismalady, admittedly caused by emotional factors as well as by movement of the plane in flight, is decreased by the use of large steady planes and by pilots avoiding turbulent air. The physician has a host of remedies to employ, utilizing sedatives, atropine, or hyoscine in appropriate doses

Psychoses —The transportation of a person with a psychosis by air or any other means is a difficult problem In the event that a patient is accepted as a passenger, he must be attended for the entire trip by a medical aid who is able to cope with behavior which can bring harm to the patient himself or to other passengers

Recently a transocean passenger was accepted for passage showing no untoward behavior the flight, however, he became maniacal cal attention at every intermediate state was required, and it was necessary to use restraint for

the latter stages of the flight.

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Transportation of Infants -Bables telerate air travel very well. The schedule is disrupted to the minimum by the rapidity of the journey Equalization of air pressure between the ears and pharynx is rapid due to the shortness of the custachian tube and wideness of the ostia physician should advise the mother to prepare formulas and carry the bottles in iced containers. The bottles can be warmed just before each feed

Epidemiology —Persons with communicable and infectious diseases should not be approved for travel until all danger of contagion is over The physician also, should be constantly aware of problems of diagnosis in the patient who recently has returned to this country from abroad.3.4 Conditions such as malaria or typhus are epidemic in foreign ports. The patient may have returned in one day to this country from a distant area where he was exposed to such conditions. At the time of onset of symptoms at the end of the incubation period, the possibility of the previous exposure which geographically seems so remote may be overlooked

### Summary

Commercial air travel is recognized generally as a comfortable and rapid means of transporta Questions do arise in the minds of medical patients as to whether or not air travel is contraindicated for their particular physical ailment. With the development of partially pressurized large planes, the fact is that only an exceedingly small number of patients should be forbidden to fly on medical grounds. The personal or industrial physician is able to make the decision, when questioned, on the basis of an understanding of the basic facts of flight physiology

Until planes are fully pressurised, so that cabin pressures can be maintained at sea level conditions, a flight does require adaptation to rapid changes in barometric pressure usually up to an altitude of 8,000 feet The adaptability of the body allows the normal individual to fly at such altitudes without any deleterious effects or discomfort A discussion of some common conditions which usually give rise to questions includes conditions of the sinuses, ears and nasopharynx. heart disease, anemia, pulmonary conditions (including the grave danger to the pneumothorax patient), and pregnancy These have been discussed briefly

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## LOW MORTALITY FORECAST FOR 1947

Barring unforeseen developments for the remainder of the year, it now appears that 1947 will set a new low record for mortality among the industrial policyholders of the Metropolitan Life Insurance Company with the death rate for the first six months of the year, 76 per 1 000 policyholders, ranking 8.8 per cant below that for the like period of last year

One of the factors contributing to the favorable record so far this year is the low mortality from influenza and pneumonia, achieved despite an un seasonable rise in the death rate from those diseases in the spring Fortunately this outbreak was shortlived and by June the death rate from influence and pneumonia was at a new low the figure for the first six months being 13 per cent below the previous minimum for this period of the year established in

Tuberculosis, too is making an excellent showing in 1947 Each month, except May registered an appropriably lower death rate from the disease than did the corresponding month of 1948, and the rate for the six months is 35 per cent under the rate ten years ago. New minimum rates have also been established so far in 1947 for syphilis appendicities and the principal communicable diseases of childhood as a group The decline in mortality from syphilis has amounted to almost 30 per cent in the past decade and from appendicitis more than 70 per cent. The death rates from measles, scarlet fever whooping cough and diphtheria together add up to less than 1 5 per 100 000 policyholders

The death rate from the diseases of the puerperal state for the first half of the year is 3.2 per 100 000 as compared with 3.1 for last year although the birth rate has increased by about 40 per cent. Like-wise with a favorable record this year are the diseases characteristic of later life. The mortality from the cardiovascular-renal diseases has declined 1.2 per cent as compared with last year and diabetes shows a drop of 5 per cent. Cancer alone registers an in-creased mortality on the basis of rates not adjusted for the aging of the insured group—Metropolitan Lafe Insurance Company Statistical Bulletin, July 1947

# CHRONIC OSTEOMYELITIS IN WAR WOUNDED A REPORT OF TWO VETERANS DISCHARGED WITH INTRACTABLE OSTEOMYELITIS AND SUCCESSFULLY TREATED WITH LOCAL PENICILLIN-DETERGENT THERAPY

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(From the Grace Clinic, Brooklyn)

IN PREVIOUS publications we have emphasized the urgency of not resorting to radical surgery in the treatment of chronic osteomyelitis unless the infinitely simpler approach of using, topically, penicillin with a detergent (Aerosol O T 01 per cent) was tried first 12 We stated that either by puddling this solution into the wound, or injecting it into the sinuses of the osteomyelitis, many cases could be cured and the ordeal of mutilating surgery, so often resorted to in the preantibiotic era, elimi-Although this approach has been helpful in many cases, it did not cure all, and a successful surgical procedure of a minor nature is now employed by the senior author in the majority of the most intractable cases This procedure merely consists in excising the sinus tract down to the diseased cortical bone, curetting an opening into the medullary canal, or, if it is too firm, drilling a large hole in order to insure the area in the medullary canal being large enough to insert a T-tube in order to maintain in this area, for ten days, a constant pool of penicillin dissolved in the detergent solution used is as follows 50 cc of Aerosol OT 01 per cent are used to dissolve 1,000,000 units of penicillin, and of this solution, 1 or 2 cc are injected every three hours When inserting the T-tube, care must be taken to be certain that the long axis of the inserted portion of the tube lies in the medullary canal parallel to the long axis of the bone soon as the bone is exposed, 2 or 3 cc of penicillin with Aerosol are injected into the infected area so that subsequent bone trauma is relatively sterile

A T-tube is not always practicable, since in chronic osteomyelitis the normal anatomy may be so modified that adequate amounts of penicillin cannot filter through the medullary canal. Therefore, in badly diseased cases, it is sometimes necessary to insert instead a rubber catheter. Irrespective of which is used (tube or catheter), it is tied to the skin by a suture and left in place for the ten-day period, during which time the penicillin-detergent solution is injected every three hours, as outlined above. A small amount of pressure is applied through the syringe, when injecting the detorgent and penicillin, to insure its deposition in the medulary canal.

The unlimited benefit that might accrue to many patients suffering from osteomyelitis in military hospitals throughout the world, as a result of war wounds, prompts us to report the cases of 2 World War II veterans, discharged from military hospitals, suffering from intractable chronic osteomyelitis with a purulent discharge and a disability directly related to this disease

Administration of penicillin dissolved in Aerosol

OT 1 1000 (dioctyl ester of sodium sulfosuccinate) is based on the observation that aqueous solutions penetrate bony tissues more readily in the presence of the detergent, presumably because of the reduced surface tension and increased lipoid solvent properties of the solution In addition, Aerosol OT has a synergistic effect on penicillin Among representative gram-positive and gram-negative bacteria commonly found in old wounds and osteomyelitis, only Pseudomonas pyocyanea will grow in proteose number 3 agar enriched with blood and containing 10,000 units of penicillin in Aerosol O T The following bacteria are killed or inhibited when tested against the penicillin with de-Staphylococcus aureus, Streptococcus viridans, Bacillus subtilis, gamma streptococcus, Proteus vulgaris, beta hemolytic streptococcus, Escherichia coli, Corynebacterium, and Neisseria catarrhalis The only one not killed or inhibited was Pseudomonas pyocyanea

Case 1—R R, aged 29 About 1927, patient had onset of swelling in right heel Since that time, has had 18 operations for condition Notwithstanding his previous history, the boy was taken into the armed services and subsequently operated on in military hospitals on 2 different occasions. He was discharged from the service on July 22, 1943, and after that, operated on in a private hospital. He was first seen by us on June 11, 1945, with a chronic draining sinus from an osteomyelitis of the os calcis

X-ray findings on June 13, 1945, of the right foot and lower leg revealed chronic osteomyelitis of the os calcis and the cuboid bones with complete fusion There were no visible sequestra

Culture was made on June 19, 1945 Broth—Staphylococcus, culture—Staph aureus, slightly

pigmented and moderately hemolytic

This patient had local instillation of penicillin through a needle down to the cortical bone in our original treatment. The disease recurred. However, when the short sinus tract was removed and an opening in the bone made adequate for admission of a catheter, the discharge stopped very promptly and the sinus remained closed. This boy is now working steadily and the lame gait associated with this osteomyelitis has disappeared, along with a cane.

Case 2—L G, aged 27 In August, 1944, this boy received a shrappel wound in the right leg that perforated the upper portion of the tibia 4 centimeters below the knee joint. In the field hospital he was given penicillin and was immediately operated on. His leg was put in a cast for a week On 3 later occasions he underwent operations in military hospitals, both abroad and in this country. He was finally discharged with a draining wound and chronic osteomyelitis.

X-ray findings on October 11, 1946, revealed the

right knee having a chronic esteemyelitis of the head and upper shaft of the tibia, a large cavity with a large sequestrum in the head of the bone, and a moderate indirect joint involvement.

A culture was done on August 22 1946 The culture from osteo sinus right leg revealed Staphylococcus albus (nonhemolytic) Proteus predomi

nated.

The magnitude of the damage done to the proxi mal end of the tibis, from which purulent discharge was exuding from both the wound of entrance and the wound of exit made it necessary to drill a hole through the cortex of bone into the medullary substance of the injured tibia and insert a catheter (wound of entrance) In the wound of exit it was merely necessary to curette through the thin cortical bone and readily insert a T tube Into both tubes 2 cc. of Acrosol O T 0 1 per cent containing 40 000 units of penicillin (20 000 units per ce) were in serted every three hours for ten days.

Three weeks following the patient's discharge from the hospital on September 14 1046, the wound was closed. Although roentgenographic evidence shows damage to the joint surface of the injured tibia, we feel confident that danger of lameness and permanent joint damage are now removed because the underlying ostcomyclitis is controlled B) has previously noted that with a deter gent the efficiency of penicillin is greatly increased by synergism, and it is worth noting that in this patient with a gram-negative Proteus infection the response to penicillin used in this manner was ex

## Summary

Provious experience with a series of 37 patients, suffering from chronic osteomyelitis in civilian life, has stimulated us to urge the same plan of therapy for the treatment of war wounded. Excellent results followed the use of this nonradical method in treating 2 veterans discharged from military service with intractable estcomvelitus.

With the advent of that important antibiotic penicellin, we must realize that an era of surgical practice has arrived that demands a complete reorientation of older forms of surgical procedures It appears possible that the mutilating treatment of ostcomvelitis by radical surgers and cauteriza tion is outmoded and should be replaced by conservative procedures employing antibiotics, as in the method described in this report.

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### DIVORCES MOUNT TO PEAK IN 1946

The long term upward trend in the frequency of divorce in the United States not only continued but actually accelerated during the war and the early postwar period It is estimated that there were more than 020 000 divorces granted in 1946 more than 11/2 times the number granted only two years carlier and almost double the figure for 1942 This means that the increase in the four years between 1942 and 1940 nearly equaled the increase from the

beginning of our history until 1942 In analyzing the statistics on this major social problem it would be instructive to know the facts with regard to individual states, but, unfortunately for quite a few of the states data on the annual num ber of divorces are not separately available. The Metropolitan Life Insurance Company through a questionnaire survey and from other sources has obtained statistical information on the number of divorces granted in 31 states and the District of Columbia for the years 1940-1940 for 16 additional states data have been gathered for selected counties, South Carolina issues no divorces at all.

Of the states for which data are available Nevada showed the largest rise between 1940 and 1946. The number of divorces there increased by practically

300 per cent in this short period from almost 5,200 300 per cent in this short period from almost o, 20,550 in at least three additional states— New Vexico Alabama, and Oregon—the number jumped by more than 200 per cent. At the other end of the scale are four states—South Dakota, Montana Virginia Wyoming—and the Dakrota, of Columbia an which the number of divorces rose by less than 100 per cent between 1940 and 1946

The figures on divorce include annulments but the latter constitute only about 4 per cent of the total legal dissolutions for the country as a whole In California and New York however annulments play a much more prominent role in some countries exceeding the number of divorces in the total of marital dissolutions.

There are definite indications that the divorce rate in 1947 will be materially below the peak established last year but there is little reason to believe how over that the long term upward trend in the divorce rate has been halted much less reversed country urgently needs to give much more attention than it has in the past to compose demestic difficultios constructively and to retard the grinding of the divorce mills —Metropolitan Life Insurance Company Statustical Bulletin July 1947

## MEDICAL DIRECTOR WANTED

The Association for Advancement of Research on Multiple Sciercals Inc. Academy of Medicine Bulking, Fifth Avenue and 103rd Street, New York City 29 New York seeks a fulltime medical director to survey and stimulate research activity in the field of multiple scierosis to assist in the organization of a rapidly-expanding institution and to aid generally in its activities. The organization has an outstanding medical advisory board A neurologic or psychiatric background is desirable but not neces-A neurologic or sary, the director must be able to travel salary will be commensurate with ability and experience.

## ESCHERICHIA COLI MENINGITIS TREATED WITH STREPTOMYCIN

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ESCHERICHIA coli meningitis is a rare and fatal It is most common in infants under three months of age,1 causing 30 to 50 per cent of the meningitides In older age groups its incidence 18 very low,2 one case in about 300 to 700 cases of meningitis (03 to 014 per cent) Shields states that in a ten-year period 776 cases of meningitis were admitted to the Charles V Chapin Hospital. without a single case due to Esch coli. In the 108 reported cases of Esch coli meningitis collected up to 1942 by Barrett, Rammelkamp, and Worcester.4 the gross fatality was 78 per cent, eight per cent recovered with complications and only 14 per recovered completely Among these were five cases treated with sulfonamides

With the advent of streptomycin, the outlook in the treatment of the meningitides due to gramnegative organisms has become considerably brighter When treated with sulfonamides, recoveries from meningitides due to coliform organisms have been reported. However, treatment has been prolonged, and recrudescences as well as sequelae have occurred Ravid's explanation,6 that Esch. coli meningitis is more apt to develop in the newborn because of the low titer of antibodies for coliform organisms in that age group as compared to adults, suggests the use of blood transfusions in the treatment of these meningitides. Since the development of resistance of coliform organisms to streptomycin during treatment7 is a factor to be considered, both sulfonamides and blood transfusions as adjuvants in the therapy of Esch coli meningitis with streptomycin would seem to be desirable

The first case of successful treatment of Esch coli meningitis with streptomycin was recently re-

ported by Alexander 8

The patient was a 19-year-old soldier, who was wounded in action and subsequently developed osteomyelitis of the tibia, Esch coli bacteremia, and Esch coli meningitis He received 18,275,000 S units of streptomycin intramuscularly over a period of sixteen days, and 650,000 units of streptomycin intrathecally in 13 injections With the exception of a persistent pleocytosis, about 200 cells (90 per cent lymphocytes), attributed to the intrathecal therapy, no complications or ill effects due to streptomycin

The second case of Esch coli meningitis, successfully treated with streptomycin, was reported by Shields 2 The patient was a five weeks' old infant, from whose blood and spinal fluid a pure culture of Esch coli communior was obtained The dosage of streptomycin was 2,630,000 units intramuscularly, 30,000 units every three hours for ten days, and 300,-000 units intrathecally, 30,000 units into the basal cistern daily for ten days. The spinal fluid upon discharge revealed 154 cells, mostly lymphocytes. The infant recovered and had no apparent sequelae

While in the two cases, cited above, penicillin and sulfadiazine were also given, the authors in each case felt that the recovery was due to strep-

tomycin

The rarity of Esch coli meningitis treated with streptomycin, as well as the satisfactory outcome,

prompts the report of this case

BZ, a nine months' old girl infant, was delivered at term, weighing eight pounds and three ounces (3,714 Gm.) She was breast fed for a few days while in the hospital and was then placed on an evaporated milk-dextri-maltose formula Both development and growth were normal. She received three injections of pertussis vaccine at four months of age and was successfully vaccinated when seven months When four months old, she had an upper respiratory infection, from which she recuperated in four days

Prior to the onset of the present illness, she was apparently well until she awoke at 3 AM on November 7 with a cry She was very irritable and felt warm. She vomited one-quarter aspirin which the mother gave her and vomited again when a bottle of milk was given Irritability and vomiting persisted. The family physician was called on the afternoon of November 7

Physical examination revealed a nuchal rigidity which was equivocal. Temperature was 101 F Penicillin, 300,000 units in beeswax and oil, was administered intramuscularly, and sulfadiazine, five grains (0 3 Gm ) with an equal amount of sodium bicarbonate, was prescribed every four hours That evening the temperature rose to 1045 F On the morning of November 8, another injection of pencil-lin, 300,000 units in beeswax and oil, was given intra-Because of the persistence of nuchal rigidity, a spinal tap was performed and an opalescent fluid was obtained. At 4 P w on November 8, another dose of 300,000 units of penicillin in beeswax and oil was injected intramuscularly That afternoon the spinal fluid was reported as consisting of 760 cells with 90 per cent polymorphonuclear cells, the sugar content was 32 mg per cent, and gramnegative rods were noted on smear The infant was visited at home through the courtesy of the family physician and hospitalization was advised

Physical Examination—The patient was a wellnourished and well-developed nine months' old girl infant with a temperature of 101 8 F, pulse of 130, and respirations of 40 The color of the skin and body turgor were normal. She was somewhat restless and irritable but did not appear very ill. cry was lusty The anterior fontanelle was normal, bulging was not present The pupils were equal and reacted to light There was neither squint nor nystagmus The throat was slightly congested. The ears were normal. The abdomen was soft, the spleen and liver were not palpable. Tremors of the fingers and hands were noted. The knee jerks were hyperactive. The Brudzinski reflex was positive. The Kernig reflex was difficult to evaluate,

and, at best, was equivocal.

Laboratory Data — The spinal fluid taken in the hospital upon admission on November 8 was bloody The fluid taken on November 9, 10, 11, 12, and 20 was persistently blood tinged, crenated blood cells were present, and the supernatant fluid was vanthochromic. This made cell counts and spinal fluid chemistry unreliable However, gram-negative rods were found on smear of the fluid taken November 9 The organism was identified by culture as Esch. coli communior Subsequent spinal fluids were negative on smear and culture. Uring examined November 10, contained a faint trace of albumin and a faint trace of sugar with occasional granular casts and moderate epithelial cells, but was normal on subsequent examination. The blood count revealed hemoglobin, 11 6 Gm., which subsequently dropped to 9.2 Gm. and following transfusion rose to 18.3 Gm. white blood cells, 15 700 to 11,600, polymor phonuclear cells, 71 per cent, which subsequently dropped to 37 per cent, and monocytes which upon admission were only three per cent and, with improve-ment clinically rose to 21 per cent. Upon discharge the monocytes had dropped to two per cent. Blood culture taken November 8 revealed no organisms. On November 14 the blood sulfadiazine level was 0.8 mg per cent.

Clinical Course and Treatment -The fover rose to 104 F on the fourth hospital day, and on the fifth day was down to 100 F It remained normal for eight days, when it again rose to 102 F time an upper respirators infection was found. Ir ritability and restlesmess were marked for four days. and by the sixth day the child was standing up in her crib alert and active. Tremors of hands and fingers were noted the first four days. Vomiting and diar rhea were prominent symptoms. Food was refused and when taken, was frequently vomited watery stools were noted on the second hospital day The vomiting and diarrhea gradually subsided so that by the fifth day the child again took and retained her Rigidity of the neck and Brudzinski reflex were prominent for four days gradually subsided, and were absent by the seventh hospital day Kornig reflex was doubtful for the first four days. The knee jerks were hyperactive markedly so for five days, and were still active upon discharge from the hospital. The general appearance of the child was good at all times. Nother nystagmus convulsion, twitchings nor cyanosis was observed. A slight internal strabismus of the left eye was noted on the fourteenth hospital day (November 21) and was present on discharge. This disappeared subso-quently. The weight was 18 pounds 6 ounces (8,335 Gm.) when the cluld was admitted to the hospital and 18 pounds 2 ounces (8 222 Gm ) upon discharge from the hospital

Upon admission, 100 000 micrograms of streptomycln were given intramuscularly and 50,000 micrograms of streptomycin were injected intrathecally Thereafter 50,000 micrograms of the streptomycin were injected intramusoularly every three hours for nine days nine days Intrathecally, through the lumbar subarachnoid route 50 000 micrograms were given daily for four consecutive days. Sulfadiazino, which had been given prior to hospitalization was continued five grains (0.3 Gm.) with an equal amount of sodium blearbonate were prescribed every four hours from November 8 to 15 Because of the upper respiratory infection, fifteen grains (1 0 Gm.) as an in itial dose followed by five grains (0.3 Gm.) every four hours with an equal dose of sedium blearbonate was again given from November 20 to November 23 The infant also recieved subcutaneous clyses of 200 cc. of five per cent glucose in normal saline on No-vember 10 and November 11 On November 12, a vember 10 and November 11 On November 12, a transfusion of 200 cc of citrated whole blood was given because of the falling hemoglobin.

## Comment

Because of the finding of gram-negative rods in a stained smear of the spinal fluid, prior to hospitalization streptomycin was instituted immediately It is also probable that the infant had subarachnoid bleeding either as the result of a traumatic spinal tap or in the course of the meningitis, since subsequent spinal fluids were persistently bloody with the findings of fresh blood cells early and later eren ated cells and xanthochromic supernatant fluid Though this made evaluation of recovery by study of the spinal fluid sugar and cell count unreliable we were able to evaluate the condition of the child by the drop of temperature to normal, the marked clinical improvement and the absence of organisms in the stained smear and culture of the spinal fluid.

After each intratheral miection of streptomy cin. the infant seemed very irritable and had a rise in temperature. After the fourth intrathecal in jection the temperature rose to 104 F Because of the marked improvement the following day we decided to withhold intrathecal therapy for one day Since clinical improvement persisted, no further intrathocal streptomy in was given. The clinical recovery on the fifth hospital day is somewhat unusual in this type of meningitis. It could not be attributed to the sulfadiazine, since due to persistent vomiting the blood sulfadiazine level after seven days of therapy was only 0 8 mg per 100 cc. of blood. According to Barrett, Rammelkamp and Worcester 4 to 10 mg. of sulfathiasole per 100 cc of spinal fluid are desirable to obtain maximal effect against Esch. coli Rapid clearing of the spinal fluid from this organism, within four days, was also reported in the other two cases1 \$ which were treated with streptomycin. The total dosage of intrathecal streptomyon was 200 000 micrograms and intramuscularly 3 400 000 units were given Since blood culture was sterile the cause of the meningitis was unknown. This has been reported in 50 per cent of the cases.4 However most likely it was due to transitory Esch. coll bacteremia. At the present time the child is well and there are no apparent sequelac

### Summary

Escherichia coli maningitis of unknown etiology in a nine months' old infant was successfully treated with streptomy can

### References

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## House of Delegates

## Minutes of the Annual Meeting

May 5 to 7, 1947

[Continued from page 2030, October 1 188ue]

Sections 95-105 appear in this issue For subject index, see August 15 issue, page 17991

## Afternoon Session

May 6, 1947

The session convened at 2 15 o'clock, pursuant to recess

SPEAKER ANDRESEN The House will be in order Dr Coon will finish his report for the Reference Committee on Report of the Council, Part XI

Section 95 (See 28, 130)

Report of Reference Committee on Report of Council-Part XI Establishment of Organization Section in New York State Journal of Medicine

DR EUGENE H COON, Nassau This is a resolution that was referred to your Reference Committee from Bronx County

"WHEREAS, sound functioning of a democratic organization is dependent upon the informed electorate, and

"WHEREAS, as our New York State Medical Society, especially the House of Delegates, is such

a democratic organization, and "Whereas, the Council acts for the State Society between sessions of the House of Dele-

gates, and
"WHEREAS, it is the custom to publish the reports of the Officers, Council, and Standing Committees in April 1 and April 15 editions of the New YORK STATE JOURNAL OF MEDICINE Just preceding the annual meeting of the House of Delegates,

"WHEREAS, this custom allows insufficient time for study and deliberation by the representative county societies to enable them to instruct their

delegates, therefore, be it "Resolved, that the House of Delegates of the Medical Society of the State of New York direct the Publications Committee to establish an Organization Section in the New York State Journal of Medicine similar to that of the Journal of the American Medical Association, and be it further

"Resolved, that there shall be published in this section all minutes of Council meetings, progress reports of all standing and special committees, and any additional information which the Council

may direct, and be it further "Resolved, that the annual reports be published in the March 15 and April 1 issues of the New

YORK STATE JOURNAL OF MEDICINE"

Your Reference Committee is in sympathy with the spirit of this resolution These reports should be published and reach the membership early consultation with our Secretary, Dr Anderton, and the Editorial Board of the JOURNAL we find that the failure of chairmen to file reports before the deadline of March 1 causes the delay in publication

Mr Speaker, I move the adoption of this report Dr Harry Aranow (Councilor) I second the

DR FREDERICK WILLIAMS, Bronx You have taken no action at all on the resolution

Dr. Coon We are in sympathy with it entirely, but we don't see that there is anything we can do except to censure the Chairmen of the Council Committees

DR WILLIAMS The purpose of introducing this resolution was purely to stop the comment and adverse criticism of young men who are coming back as veterans and saying they will not join Organized Medicine and are not interested because they do not have a voice in it, which we know is not true. The reason they feel they do not have a voice in Organized Medicine is because they are not informed of our problems that come before the Houses of Delegates of both the Medical Society of the State of New York and the American Medical Association and the respective committees that make the decisions. They only hear the decisions later. We felt that if there was some directive introduced whereby these committees would see to it that their reports

got in early then the problems would be presented more to the members and we would not be confronted with this criticism of members saving they don t have a part or voice in the democratic functioning and proceeding of our organization was the purpose behind this resolution

The report of the Reference Committee to me seems to be a very innocuous and ineffectual recomdation and surely would not accomplish the aim and

goal which our resolution was intended for

Dr. Leo F Schiff, Clinton If I recall the reading of the resolution correctly, there were two parts to it one of which required the publication of an Or-ganization Section in which the minutes of the Council and other pertinent activities of the officers of the Bociety should be published from time to time, so that we might know before the time of the annual reports what was going on The second had to do with the publication of the reports as to the exact date of issue

Personally, I feel that some form of notification to the members of the most important activities of the Council and its important committees during the year would be of great benefit to us all rather than have us wait for the annual reports

I move you, Mr Speaker that this report be referred back to the committee as its recommendations in my mind are incomplete and do not cover the subiect entirely

The motion was seconded, and was put to a

vote, and was carried.

SPEAKER ANDRESEN It is referred back to the Reference Committee.

## Section 98 (See 32)

Report of Reference Committee on Report of Council-Part XI News Releases of American Medical Association

Dr. Eugene H Coon, Nassau On the second resolution from Bronx County reading

"Whereas the American Medical Association issues a release each Friday on the content of articles appearing in the forthcoming Journal of the American Medical Association and

Whereas these releases reach the public through the newspapers before the physicians have received their Journal containing the com

plete article and

WHEREAS, patients partially informed through these releases frequently ask their physicians

about such items, and

WHEREAS, these questions have been a source of embarrassment to the medical profession and have tended to affect adversely the confidence placed by the patient in the doctor's knowledge of current scientific advances therefore be it

"Resolved that such advance press items should be either discontinued altogether or released after actual receipt by the medical profession of the American Medical Association Journal and be it further

'Resolved that the delegates to the convention of the American Medical Association from the Medical Society of the State of New York be in structed to seek the passage of a similar resolu

Your Reference Committee agrees with this resolu-

tion and I so move

The motion was seconded, and as there was no discussion, it was put to a vote and was unant mously carried.

Section 97 (See 14)

Report of the Reference Committee on Report of Council-Part IX Legislation

DR ANDREW A. Eggston Westchester Your Reference Committee upon Legislation must in the first instance mention the very excellent work of the Legislative Committee We recall that, during the entire session of the Legislature many and detailed bulletins were sent to the various members of the County Legislative Committees acquainting them with what was transpiring in regard to medical legis lation during the past session. These bulletins were short concise and most instructive in regard to the attitude of the profession upon these issues many of which were of vital concern to the practice of medi cine in this State Therefore it is trite that a brief reference be made about the subjects considered Noteworthy is the fact that 5 200 bills were introduced in both Houses of the Legislature Of these, 157 separate bills were of interest to medicine.

A chiropractic bill of course came to life in the assembly and Senate but met the same rate as its

predecessors much to the good of the public. In regard to the question of vivisection it is well known that medical men are in sympathy with all humane animal experiments and are glad that such animal experiments be permitted under inspections and approval by the State Health Commissioner This should certainly satisfy those who do not under stand or sanction essential animal experiments.

Of special interest but entirely expected was the bill that Assemblyman Farbstein re-introduced, which was essentially a copy of the Murray Wagner Dingell Compulsory Health Insurance Bill. bill was not reported out of committee Th This was

good but we advise continual vigilance.

A 1 275-page Education Bill was passed and as there was little controversial matter which could be

judiciously amended the bill was approved.

Although fully aware of the fact that the Legisla tive Committee supported the Clancy Bill because it would declare the practice of reentgenology as the practice of medicine, your Reference Committee disagrees with the advisability of this support because it would allow both podiatrists and dentists to diagnose and treat by x ray and radium any part of Your Committee feels that the dentists the body should confine their use to their own field as contained in the Dental Practice Act and that podia trists should not be given such privileges tunately the Clancy Bill did not become a law

The educational law which would permit physicians to practice as partners also insurance companies to practice medicine on their behalf or for their insured by contract physicians, partners, or groups of physicians was disapproved not upon the grounds of group or partnership practice, but rightly upon the grounds of the establishment of Your Reference Committee corporate medicine approves of this action
The efforts of the Legislative Committee to define

and legalize specialties of roomganolgoy anesthesiology physiotherapy and pathology as the practice of medicine are to be commended.

Mr Speaker, I move this part of the report be

ndopted.

The motion was seconded and as there was no discussion, it was put to a vote and was unani-

mously carried DR. EGGSTON Much time and consideration, and statistical data in regard to a Basic Science Law was the subject of an exhaustive survey by your Medical Practice Committee

Your Reference Committee urges that all delegates read the entire report of that Committee

It is the opinion of your Reference Committee after much deliberation that a Basic Science Law has not been, and will not be, an effective deterrent to cult practice. To advocate a Basic Science Law is a serious step that may disrupt our present law, which gives us a unified Board of Medical Examiners

This conclusion is supported by the existence of numerous examining boards in many states which

have Basic Science Laws

Your Reference Committee recommends the approval of the recommendation of the Medical Practice Committee that the Medical Society of the State of New York should not sponsor a Basic Science Law

I move the adoption of this portion of the report DR WILLIAM B RAWLS, New York I second the

motion

DR CHARLES F GULLO, Laungston I ask that this part of the report be tabled until such time as the action of this committee in reference to the resolution from Livingston County on this subject is There has been a resolution introduced acted upon in line with this subject, in which we ask for an executive session to discuss it We want to know the report on that resolution first rather than duplicating the effort

Speaker Andresen A motion has been made to table this portion of the report until the report on the other resolution has been presented. Is there a

second to that motion to table?

DR FREDERICK B WETHERELL I second the motion

The motion to table was put to a vote, and was lost

DR GULLO What is the result of that? SPEAKER ANDRESEN Your motion was lost, and the decision on the report of the Reference Com-

mittee will have to be taken up immediately
DR GULLO May I take it up now then?
SPEAKER ANDRESEN Yes, but I would like to call your attention to the fact again that you have five minutes and can speak only once on any subject

DR Gullo Mr Speaker and Members of the House of Delegates, I don't like to talk five minutes, and would prefer to finish in less time, but I would like to ask you one favor. This is not my baby, it is our baby. I would like to ask you for the privilege of speaking more than five minutes on this subject if I have to, but certainly not more than ten

SPEAKER ANDRESEN Do you want me to put such a motion now or wait until your five minutes are up?

DR GULLO I would rather have it now SPEAKER ANDRESEN If someone will put such a

motion, I will entertain it

Dr. Wetherell I move he be given ten minutes DR JAMES R REULING (Trustee) I second it SPEAKER ANDRESEN The motion is to allow Dr ullo ten minutes All in favor say "Aye", con-Gullo ten minutes All in favor say "Aye", contrary, "No" It is about even Let us try it again All in favor of allowing the ten minutes say "Aye" all those against allowing the ten minutes say "No".

The Chair is uncertain We will ask you to stand

DR WETHERELL I ask for a standing vote SPEAKER ANDRESEN There has been a call for a standing vote All in favor of allowing him ten minutes will stand, now all those against it will stand. The "Ayes" have it, there are 97 in favor of allowing Dr Gullo ten minutes

You are allowed ten minutes, Dr Gullo DR WETHERELL Stick to the point, Gullo DR Gullo Thank you, gentlemen!

The answer of those of us who have advocated this particular subject for the past years is based upon two ideas of medicine, the only ones that make pos-sible the existence of Organized Medicine. It was said here not long ago by Dr Cuniffe and some years ago by Dr Gordon Heyd as president of the American Medical Association that Organized Medicine exists for only two reasons one, to disseminate knowledge to its members, two, to protect the public health Only because of those ideals have we striven to bring this about That is the only objective that we have had

Your Legislative Committee made this report, but two years ago when Dr Cottis made his recommendation he asked for certain factual data We beheve that certain factual data have been left out of

this report

We asked for an executive session in our resolution for this reason We have some very confidential in-Some of your officers know what it is, formation for I have told them about it I certainly cannot mention the name of this particular man who gave us this information, but this I will say to you without mentioning any names Dr Winslow and myself last year visited this particular gentleman, who is very high in the Legislature, as high as you can possibly think—well, not quite that high, but he is very near the top—and this is what he had to say He said, "You don't have to worry about the Vivisection Bill, we will take care of that," but we did our job just the same However, within two minutes he finished that off by saying, "How about the Chiropractic Bill? You know we have been holding this off for a long time. The State of New York is the dumping ground of cults, and it is time that their growth is arrested, and something will have to be done about it soon "

In effect, he meant briefly that we ought to look into the history of what has happened here from 1907 and throughout the nation In 1907 we passed the Medical Practice Act with the idea that it would take care of every body. The same thing happened in other states. The chiropractors and all cults in the State of New York have grown just the same We know we have not done anything with them other states where they passed a Medical Practice Act, the same thing happened, but then they turned around and they passed licensing acts for that particular cult. They were not able to control cult practice either with the combination of the Medical Practice Act and the licensing act, or either alone, any more than we did with just a Medical Practice Act The success of a law, of course, depends upon whether or not it accomplishes its objective In 1925 Wisconsin and, the same year, Connecticut—I think it was Connecticut—passed what is known as the first Basic Science Law Since then 17 other states plus the District of Columbia have enacted such a law

What happened in those states? Immediately the number of cultists licensed in those states dropped from there on In Minnesota, for example, it dropped—and these are the factual data that you do not have here-from 46 per year to 2 per year, in the State of Washington from 63 to 2, in Nebraska not a one has been licensed since the law was enacted, in the District of Columbia the same thing Now to get some data that were handed to us by our Executive Secretary, Dr Hannon, and sent to each one of the secretaries of our Societies He states in this report that in 1943 there were nine chiroprac tors able to pass the Basic Science Law in those When you compare that with 60, 43, 46, 64,

63 and 46, there are about 250 who would have been licensed in those states per year if the law had not been enacted To get near the conclusion 250 over a period from 1925 to today is 6 000. Approximately you can say that 3 000 of those people certainly came

to New York State

How sorious is this problem in the State of New lork really? Nobody knows The report here says that there is one chiropractor to every fourteen doctors. That is 2,000 Well, gentlemen I don t know where they got that dope from, but that is the exact figure that appeared in Medical Reconomics several years ago, and I wrote to those people and sald, "Where did you got that figure from?" and the answer was "Well the chropmetors gave us that figure." So nobody knows, but this we do know, that in the State of New York there are 6 000 com munities, municipalities which are incorporated and have a population of 25 000 or less Well, if you were to take the telephone directory for each of these municipalities, and to look up the classified directory you will find on an average at least one chiropractor in that community and that is 6,000 in the State of New York at least, and in doing that we are forgetting New York City or Buffalo or Rochester, or Syracuse

During this time that we have brought this up to you we have introduced this measure—not intro-duced but we have presented—we have presented our facts (and they are not our facts, they are sent to us) to the various county societies and ten of these societies have endorsed it These societies are Westchester Madison Livingston, Wyoming Steu ben, Niagara, Chemung Onondaga Broome, and Chautauqua counties If such men as Dr Cottis, and if such men as Dr William Johnson and if such men as Fred Wetherell and if such counties as Westchester and Onondaga say that this is just what we have been looking for, I cannot understand your

attitude.

And what have we been looking for? When you prosecute an individual in this State, you prosecute him for violating the Medical Practice Act, but you always get acquittals or the jury is hung Because invariably you fail to convince them that he violated the Medical Practice Act. By this the law is changed Our proposition does this It creates a Basic Science Low with a Basic Science Board which provides for examination in the basic science board winds a provides for examination in the basic sciences and gives a qualifying certificate The end result in the State of New York, if we had one now would be this You would have one licensing examining board You would have the Basic Science Board to issue a qualifying certificate, and as you legislate for something that exists you certainly don t legislate to make legal criminals, so you leave them out of the Basic Science Law You include the definition of the practice of healing, which is the heart of the Basic Scenee Law and you would prosecute him for practicing bealing, not medicine That is separate and distinct, and bealing is not now a part of the State of New York Medical Practice Act attempting to practice medicine is all you can now attempt to prosecute him for Consequently, you would have a separate basic science examining board and because it is difficult to get convictions the prosecuting attorney would have an opportunity to prosecute these people, who often bring about the death of those they attempt to heal, for practicing bealing without a qualifying certificate

In conclusion the Supreme Court of Minnesota in a test case—it was not a test case—concluded when a particular cult which was not licensed (it happened

to be naturopaths, we have chiropractors, but it was the same anomalous situation, the naturopath was being prosecuted for violating the law) was brought before it that the state has the power within its police power to regulate but not heense. That is what we are trying to do to establish in advance the protection to prevent the eventuality that happened in 1938 when the Medical Practice Act was amended in spite of our efforts.

SPEAKER ANDRESEN Is there any further discussion?

DR. GULLO The reports I got were from the Secretary—may I speak one minute more? Chorus You spoke ten minutes already

DR. WETHERELL Get down DR. WHALAM B RAWLS, New York Mr Speaker and Members of the House of Delegates, as a member of this Reference Committee I would like to say that your Reference Committee considered all of the facts that have been presented by Dr Gullo think we spent something like six hours on them We have been in detail over all of these reports. have considered the facts that he advanced, that perhaps if you had one examining board you might climinate cults. After a thorough study we could find no evidence that the passage of the Basic Science Law would eliminate cults We find evidence that, where there was more than one examming board they might accomplish something, but as far as it applies to Now York, where at the present time we have one unified Board of Medical Examiners, that to interfere with the present Medical Practice Act might open it up to what we might not like After the politicians get through with it, no one knows what would be left. We felt on that basis that we should not interfere with the Medical Practice Act, that it would be a dangerous procedure, that we had no proof it had accomplished any thing before and we felt one unified Board of Medical Examiners is about the best protection we could have

Furthermore, if we have a group of young people taking this examination in the basic medical sciences we will have a greater number who will want to enter into some form of the practice of medicine As you know all of our medical schools are now crowded, so there would not be room for them in the medical schools, and we believe we would have more taking to the practice of cultism than we have at the present moment

SPEAKER ANDRESEN Is there any further discussion? If there is no further discussion all in

favor-DR. GULLO May I make a motion to the fact that this report of the Legislative Committee be sent back to the Council for final decision?

DR. WETHERELL I will second that I would like to talk to that motion, Mr Speaker if I may

SPEAKER ANDRESEN Yes.
DR. WETHERBILL Mr Speaker and Gentlemen, I have not talked on this before, but I have definite ideas on the subject, as you may have gathered from what Dr Gullo said It seems to me that it is un fortunate that the opponents of the Basic Science measure in New York State so often take their opponents arguments as a reflection on their personal ability and loveliness. There is nothing personal in this but it has come to me in a great many ways and I have nearly lost friends because of the study we have made.

I looked through the report of the Legalative Committee in the JOURNAL and found this That we are morally obligated to protect the health interests of the people of the State of New York At last that is in writing Is it or is it not, then, one of our moral obligations to see to it that in some way, although it takes fighting year after year after year to keep down the cultists who are entirely unprepared to touch a sick human being, that we eliminate all

In the supplementary report, which is to me a rather scanty one although I know a great deal of work was done on it, the fact is brought out that such a law has been enacted in Kansas and in other states Of course, we are to assume that New York State is not able to instigate proper legislation for the control of cults That is what we are in effect assuming when we take the negative action we are taking today is possible for the Kansas Board of Medical Examiners to go into court and obtain injunctions against unlicensed practitioners of the healing art, and they do it The same is true in Minnesota, although that is just barely scanned over in this re-

Two other factors appear to be of considerable value in keeping down cult practitioners these is the use of the injunction whereby it becomes necessary only to demonstrate to a judge the illegal nature of a defendant's practice in order to restrain him effectively from such practice rather than having to submit the case to a jury. The other procedure which appears to help the situation is the investiture of the State Board of Medical Examiners (as is done in Minnesota) either with actual or with unstated but generally accepted legal powers to investigate and prosecute violators of the medical practice New York State does not have a regulations separate Basic Science Law, and despite all of the arguments against it Dr Adson, who was very much interested in medicine and medical practice in Minnesota, told me they can pick them up, and do pick them up, and no new ones are coming into Minnesota because it is just the same as if you are driving a car without a license, the police officials do not have to prove anything, they simply assert you have not your license

If this report goes through, I would like to have someone who is much better versed in the formation of resolutions than I am to present a resolution that the matter of injunction and further investiture of our State Board of Medical Examiners be such that they can prosecute, or are we just going to sit down and year after year spend the State Society's money to keep the chiropractors from being licensed? Well, they are going to be licensed, and I have been told it by several legislators, including some of the very top executives

DR HARRY ARANOW (Councilor) I think we cannot help but admire the sincerity and perserverance of Dr Gullo, but after all this is a democratic country, and we are ruled by the majority thing has come up again and again and again, and it is up to the majority of the men present to decide We have had hearings before this House had these gentlemen appear before the Council We have had them appear before committees Last year they appeared before a committee of which I We have sent out for information was chairman and have made inquiries all over the country, and after all of our study we are not convinced that the Basic Science Law will do anything at all to prevent As long as there is a practice of medicine which requires a great deal of study and preparation, there are going to be quacks. There have been quacks in the history of medicine from the very beginning, and they are always going to be there

There is aways going to be somebody who is going to try to practice some art of healing, and if you' don't get it from the chiropractors it will be from

another group

This committee, with all due respect to the other gentlemen, feels that the Basic Science Law is not going to do a thing Besides that, the Basic Science Law does not make the thing final Next year they can bring in another amendment and change it There is no law in this country that prevents a man from bringing in a bill to change that which has been passed the year before They can change it again, From the studies we have and again, and again made we have come to the conclusion that a Basic Science Law will not do anything at all to prevent chiropractors from going ahead the way they have been doing

DR GULLO But—

SPEAKER ANDRESEN We cannot allow you to speak again

DR GULLO May I ask for thirty seconds more?

SPEAKER ANDRESEN For what?

DR GULLO Just to show something from which you can see for yourselves its efficacy

Speaker Andresen I am sorry, but we will have to take a vote of the House before you can do that You will have to ask the consent of the House before you may speak again on this subject

DR EZRA A WOLFF, Queens Give him the unanimous consent of the House to do that

CHORUS Yes

DR GULLO Thirty seconds will be too long statement was made that the Basic Science Law does not work The test is Does it prevent the licensure of cults in the states that have the law, and can you get prosecutions and convictions? The State of Minnesota in its letter from the Executive Secretary, and I am willing to turn it in as evidence, says that after investigating 800 cases 250 were prosecuted and they got 90 per cent convictions

(Chart) Here is what happened in Minnesota By 1977, there won't be any By 1953 there won't be

anv

(Chart) In Nebraska, that is the graph, gentlemen, and anybody who wants to look at the data right here from the executive secretaries of all of these

The two charts have been handed in separately ) DR REGINALD A HIGGONS, Westchester men, I want to say just a very few words I have gone into the information that Dr Gullo has presented to you scantily, and I am just as convinced that there is truth in it as Dr Aranow is that there is We both look at it with honesty of purpose, but we look at it with a different result

I live in Connecticut, just over the Connecticut line, in a town which is rated as being one of the wealthiest in the United States, so would be a golden field of endeavor for chiropractors adjoining town just across the line, where the populations are equal, there are probably ten chiropractors
In this town of Connecticut that I refer to, I know
of none—not one That is just one of the facts that
I happen to know because I live there

What I think ought to be done with this thing is another attempt should be made in honesty to determine whether or not the best way out for us is a Basic Science Law What we have done in the past Basic Science Law What we have done in the past has completely failed What they say they are going to do in the future is very likely to continue to fall because what we do is nothing It is all right to say, "Enforce your Medical Practice Act," but I defy any of you to tell us how to do it It can't be

done. It never has been done and it never will be done

DR. FELIX OTTAVIANO, Madison If our delegated visitor from the State of Connecticut is here could we ask that he express his opinion on this as it applies in Connecticut?

SPEAKER ANDRESEN Dr Howard, will you

oblige? DR. JOSEPH H HOWARD Mr Speaker and Mem bers of the House, I am sorry that I have not any figures with me to tell you how many of these cultists are licensed in Connecticut. I can assure you it has been cut down considerably under the Basic Science Chiropractors occasionally pass the Basic

Science Board, so it does not climinate them en tirely but it has very definitely cut them down to a I am sorry I cannot supply you with minimum

authentic figures

Dr. Ottaviano Mr Speaker I am a member of the Reference Committee which is giving this report and went along with the report purely because we knew that if it came up in executive session it would probably be squelched, but I should like to have my say now We have heard from the visitor from Con-necticut Dr Aranow states, as do many others who are older in this Society than I am that for the past so many years we have heard it, and he insists on the workings of the democratic process. I also insist that that process work. It can only work if we give each man his day in court. I wanted to limit discussion even to a certain limit of time but that did not seem to be appropriate

The statement was made that it does not work in We have just been told that appar ently it does Therefore gentlemen whether you are for or against it you must at least be willing to

laten to the facts

BPEAKER ANDRESSEN Is there any further dis-cussion? If not, we will put it to a vote All those in favor of the recommendation of the Reference Committee which is against the Basic Science Law-

Dr. Gollo No there was my motion to refer which takes precedence that the report be sent back

to the Council

SPEAKER ANDRESEN But the Council has been orking on it for years The motion then is to refer

working on it for years the report back to the Council-

DR WETHERELL The motion is that the report be referred back to the Council, the report of the Legislative Committee on the Medical Practice Act I would like to say that if this is voted the Council will have the opportunity to put on the investigating committee one or two members who are for a Basic Science Law and not all members who are against it (Applause)

DR. ARANOW I am sorry to get up again but this thing was referred to the Council last year— SPEAKER ANDRESEN I can only give you half a minute You have discussed this before

Dr. Aranow It was referred to my committee, the committee of which I was chairman neither for nor against it. As you know I have been fighting for the benefit of the medical profession for years. If I thought for a minute that the Basic Science Law would help us I would be for it

Dr. D DEXTER DAVIS Gentlemen you have heard from the State of Connecticut, and I would like to tell you about the State of Vermont. To pass a Basic Science Law in the State of Vermont there was one group that was willing to go along with the medical profession, and that was the ostcopaths.

The chiropractors were entirely unwilling. When it came down to discussing this question—and you

will find the same thing happened in our State Legislature-when it comes to passing a law such as you are trying to pass or talking about passing you are going to have the chiropractors come to the legislature against it. That is why they did not pass it in the State of Vermont this year because the chiropractors said that this would legislate out of existence every chiropractor in the State

The motion to refer back to the Council was put by viva voce vote and as there was uncertainty

as to the outcome it was put to a standing vote
SPEAKER ANDRESEN You are now voting on the motion to refer the report back to the Council. The vote is so close to a tie, and there are so many chances of error that we will put it to a standing vote I will ask Dr Wetherell to act as one of the tellers

The motion was put to a standing vote

SPEAKER ANDRESEN The motion to refer is lost. Now we come back again to the report of the Reference Committee

Dr. Samuel Z Freedman, New York We have heard representatives from Vermont and Connecti We have a representative here from Pennsylvania, where they also have a situation which might be of interest to us, and I suggest that you call upon

CHORUS No.

Dr. Aranow We have written to every state in the union for information. It takes more than one

swallow to make a summer

The motion on the adoption of the report of the Reference Committee which was contrary to the Basic Science Law was put to a viva voce vote, and as there was uncertainty as to the outcome, it was put to a standing vote and was carried
SPEAKER ANDRESEN The recommendation of the

Reference Committee which carried with it disapproval of the Basic Science Law was carried by a

vote of 94 in favor to 63 against

DR. Eggston Please do not hand me any more hot potatoes . The work on that committee was very difficult, but I think a thing that calls out as much discussion as this has had really shows a great interest in furthering what we all want to do Any thing that brings out that much interest shows that we are all very much concerned about the practice of medicine in this State, and I think it is very healthy However, that is beside the point

Your Reference Committee wishes to voice its appreciation of the tremendous amount of work done by both the Legislative and the Medical Practice Committees

I move the adoption of the report as a whole The motion was seconded and as there was no discussion it was put to a vote and was unani

mously carried

Section 98 (See 33)

Report of Reference Committee on Report of Coun cil-Part IX. License of X Ray Departments as Laboratories

DR ANDREW A EGGSTON Westchester I have a bunch of resolutions that were handed to my com-

This resolution concerning the heense of x ray departments as laboratories of hospitals was introduced by Dr Nelson W Strohm of Eric County

WHEREAS, there has been enacted a law which ermits hospitals to license x ray departments as laboratories and

"WHEREAS, this law is in conflict and circumvents Chapter 466 of the Education Law of 1944 and Chapter 307 of the Workmen's Compensation Law of 1941 relative to the division of fees. und

"Whereas, this permissive law does not serve the best interests of the citizens of the State,

especially the ill, be it

"Resolved, that the Counsel of the Medical
Society of the State of New York proceed legally to test the validity of this Act or Law"

Your Reference Committee agrees in principle with the resolution However, because of the many factors involved in preparing a legal testing of the validity of the law, which requires further study, your Reference Committee therefore recommends that this resolution be referred to the Council

One of the things that it entails is the expenditure of moneys I don't think we are qualified to give you

a definite opinion on that

I move the adoption of this report

The motion was seconded, and as there was no discussion, it was put to a vote, and was unanimously carried

Section 99 (See 90)

Report of Reference Committee on Report of Council-Part IX Status of Employment of Radiologists by Hospitals on Salary

DR ANDREW A EGGSTON, Westchester This is a resolution introduced by Dr Porter A. Steele, of Eric County, concerning the status of employment of radiologists by hospitals on salary

"Whereas, the 1947 State Legislature enacted on amendment to Section 13-c(2) of the Workmen's Compensation Law which permits hospitals to employ radiologists on a salary basis, and

"Whereas, this new law is inconsistent and is in conflict with Section 1261-4 of the Education Law and Section 13-d (2g) of the Workmen's Compensation Law, which prevent hospitals from employing radiologists on a salary basis, and "Whereas, these statutes will result in a great

deal of confusion in the minds of radiologists as to whether they may accept a salary, therefore, be

"Resolved, that the counsel of the Medical Society of the State of New York take legal steps to secure an interpretation of the statutes relating to the permissible financial relationship between hospitals and radiologists'

Whereas this resolution and the previous one just acted upon are closely related, your Reference Committee recommends the same action as upon the previous one, namely, that it be referred to the Council of the Medical Society of the State of New

York I so move The motion was seconded, and as there was no discussion, it was put to a vote, and was unani-

mously carried

Section 100 (Sec 84)

Report of Reference Committee on Report of Council-Part IX Head of Federal Health Department to Be a Physician

DR ANDREW A EGGSTON, Westchester We have another resolution introduced by Dr Leo F Schiff, of Chinton, which has as its subject, "Head of Federal Health Department to Be a Physician"

"Whereas, there have been introduced into the Congress of the United States bills having for

their objective consolidation of all Federal Health Activities under one head, and there is likelihood that other bills for the same purpose will be introduced, and

"WHEREAS, the methods proposed for effecting the consolidation of these activities vary in the various bills, particularly as to the administrative setup whereby in some instances the health activities are only a subordinate part of some other

department, be it "Resolved, that the Medical Society of the State of New York believes it to be to the best interests of the people of this country that all federal activities having to do with the public health be consolidated under one head and that such consolidated body be set up as an independent body under the administrative direction of a physician and not be consolidated as part of a department having other functions in addition to the public health

Your Reference Committee recommends the approval of this resolution

DR WILLIAM B RAWLS, New York I second the motion

SPEAKER ANDRESEN Is there any discussion?

PRESIDENT BAUER Mr Speaker, point of information I understand the Planning Committee's report contained material on this same subject Can the Chairman of the Reference Committee tell us how that ties in with the report already adopted by the House?

DR EGGSTON I was so busy with this other matter that I did not hear the report of that Committee

nor am I familiar with it

DR LEOF SCHIFF, Clinton May I answer that? SPEAKER ANDRESEN Yes, please do

DR SCHIFF Answering Dr Bauer, this is entirely in accord with the report of the Reference Committee that Dr Bauer speaks of At that time it was simply to emphasize something which had been adopted by adopting the report generally that this was introduced

PRESIDENT BAUER I do not have any objection to the motion of the Chairman I just wanted to be sure we were not adopting two different procedures on the same subject As long as this is in accord I am glad to second the motion

DR O W H MITCHELL (Councilor) I think the wording of that resolution should be that the head of such department should be a doctor of medicine As it is now it just says "a physician"

DR SCHIFF I will accept that SPEAKER ANDRESEN That amendment has been accepted by the proposer How about the Reference Committee?

DR EGGSTON We will accept that

The question was called, and the motion was put to a vote, and was unanimously carried

Section 101 (See 80)

Report of Reference Committee on Report of Council-Part IX X-Ray Diagnosis

Dr. Andrew A Eggston, Westchester diagnosis is the subject of the resolution introduced by Dr Aaron Kottler, of Kings County

"WHEREAS, a bill to amend Section 1250 of the Education Law of the State of New York in relation to practice x-ray diagnosis and treatment, and treatment by radium was introduced in the 1947 legislature, which bill was not passed, therefore be it

'Resolved, that the Medical Society of the State of New York request that a bill be introduced in the New York State Locislature in 1948 as follows

X my diagnosis means that method of medical practice in which demonstration and examina tion of the normal and abnormal structures parts or function of the human body are made by use of x rays, and any person who holds himself out to diagnose or able to make or makes any interpretation or explanation by word of mouth, writing, or otherwise, by the meaning of a fluoroscopie or registered shadow or shadows of any part of the human body made by the use of x-rays and also the use of x rays or radium for the treatment of any human ailment, shall be deemed to be engaged in the practice of medicine within the meaning of this article, and Section 1202, as follows The provision of this article shall be deemed to prohibit the practice of x ray diagnosis, x ray therapy, or radium therapy, as defined in subdivision ? A of Section 1250 of this chapter by any person other than a person licensed as a physician a dentist, an osteopath or a podiatrist. Be it further

Resolved, that the Medical Society of the State of New York actively work for the passage of such a bill in the Legislature during the year of

1948.

Your Reference Committee recommends the approval of this resolution with the deletion of the following words a 'dentist, an osteopath, or a podiatrist ' Your Committee further recommends that in the cases of dentuts and esteopaths this resolution may only apply in so far as their respective practice acts specify I move the adoption of the

Da. William B Rawls, New 1 ork I second it As this resolution was worded it would appear that the House of Delegates would be going on record as trying to sponsor a law to favor the practice of x my by the podiatrists and the esteopaths We are in favor of the basic principle of the resolution but we desire to eliminate the words osteopath and podi atrist' and so qualify it according to what the Medical Practice Act states it may be It was because of that that we made the change in wording in the resolution. We felt that the Medical Society did not want to be actively engaged in the support of a law to put across the practice of osteopathy or

podiatry
Da. HARRY ARANOW (Councilor)
Da. HARRY ARANOW (Councilor) The ordinary lay person is not in a position to draw up a bill. You an only give the continent that the bill when drawn up about a present and the continent that the bill when drawn up about express. There is a regular organization in Albany that draws up bills. If you give me a definite rule as recommended in the first clause the definite rule as recommended in the mile have to go bill may not even be legal. It will have to go through a drafting organization. It is all right as have tred to get that for years Therefore I don't know that it is a good idea to tell the Logislative Committee to get a !lil passed as stated because it may not be a good bill at all. It has to be drafted by We are in sympathy with it, and have experta tried to do it for years.

As far as the Clancy Bill is concerned, we have tried to put in a bill for a number of years in Albany that would make the interpretation of x rays the practice of medicine. Years ago there was a de-cision of the Supreme Court that the interpretation of an x ray film was not the practice of medicine The Clancy Bill came in at the end of the session and we were afraid that if we tried to do any cliang ing in it, it would not go across at all, and we were anxious to get it across. It is my experience that rather than take nothing it is better to take that which you can at the moment, and try for more later on, so we were willing to support the Clancy Bill in spite of the fact that its wording was not very good

DR JAMES R. REULING (Treasurer) In the reference committee report, they again use the word It should be changed to doctor of physician. medicine' Are they willing to change it or will I

make a motion to that effect?

DR. EGGSTON 1 cs, we are willing to make that

DR JOSEPH A GEIS, Essex. It seems to me that in the wording of this resolution we are asking Dr Aranow to do the absolutely impossible He has been mixed up with this stuff long enough to know what we want I know some of the work he has done in the past ten or fifteen years in connection with this and I cannot see any reason for passing this resolu-tion because it may not be possible for him to do it the way it is worded

DR. AARON KOTTLER Kings The wording of that resolution is identical with the bill that was introduced last year It has already gone through

this drafting committee

Dr. Ananow We approved of that bill last year DR. KOTTLER I don't know if we did but I do know this is an exact copy of the bill that was in committee in the State Legislature and never came out of committee

Dn. GEIS That s the point I am making It has been in the State Legislature for three or four years, and if it gets out of committee in one house it dies in committee in the other. As it is worded now I doubt if it can be brought out of committee onto the

floor of either house

Dr. Korrler I have no objection if this delega tion would approve this recommendation in principle, and the proper wording of it to be delegated to a proper body who would see that this resolution is

correctly framed into a bill.

DR HOMER J KNICKERBOCKER, Onlaria cannot direct our Legislative Committee to adhere to any specific draft of any bill which we might wish to have introduced. We can refer the matter to them with the request that they embody the prin-ciples involved in a proposed bill to be introduced and I so move you.

SPEAKER ANDRESEN Do you want to have it referred back to the Reference Committee to do it?

DR. KNICKERBOCKER No we cannot definitely limit the wording of any bill which we would like to have introduced at a meeting of this character, no matter how carefully the resolution is made There are legal and legislative reasons why it could not bass if it was put through. I believe Dr Aranow's Committee is in a position to give us the best advice along those lines. They are capable, with the assistance of other committees in the Society of drafting some bill which will have a chance to pass I think we could definitely refer this matter to the Logislative Committee with a request to produce such a bill.

DR. RAWLS I would like to substitute if it is in order, that the House of Delegates approve this in principle to refer it to the Council for proper word

DR. KOTTLER I second that.

There being no discussion the question was put on the substitute motion and it was carried.

SPEAKER ANDRESEN Now we come to the substitute motion Is there any discussion?

There being no discussion, the motion was put, and was carried

SPEAKER ANDRESEN Thank you very much, Dr

Eggston!

Dr Eggston wishes me to announce he is going to have a meeting of his committee immediately, across the hall

Section 102 (See 8, 47, 38, 104)

Report of Reference Committee on Malpractice Insurance and Defense Board

On Motion by President Bauer, seconded by Dr Frederick S Wetherell, Onondaga, the House went into Executive Session, and took up the Report of the Reference Committee on Malpractice Insurance and Defense Board

Section 103

Report of Reference Committee on Report of Legal Counsel

The House also considered the Report of the Reference Committee on Report of Legal Counsel

Section 104 (See 47)

Report of Reference Committee on Report of Malpractice Insurance and Defense Board Resolution on Appointment of Committee

DR A. W MARTIN MARINO, Kings Your Reference Committee recommends that the following resolution be substituted for the resolution offered by Dr Bauer

"Whereas, the House of Delegates in 1944 directed the appointment of a committee to make a survey of the entire malpractice insurance and defense situation in the State, and

"WHEREAS, the committee was duly appointed, and reported to this House at the regular meeting

in 1945, and

"WHEREAS, after due notice the Constitution and Bylaws were amended to create a malpractice insurance and defense board, and

"Whereas, this board was created by the House of Delegates at the regular meeting in

1946, and
"WHEREAS, the insurance board is a duly authorized agent of this House of Delegates, and "Whereas, the insurance board has functioned

during the past year, and

"WHEREAS, the House of Delegates at the regular meeting in 1946 authorized that an audit be made of the malpractice insurance program, and a report based upon the result of the audit has been submitted to this House, and "Whereas, the value of such audit can be con-

tinued and made increasingly useful, therefore be

"Resolved, that the Malpractice Insurance and Defense Board be charged to continue the survey of the malpractice insurance situation, and be it

"Resolved, that the said Malpractice Insurance Board shall be required to apprise this House from time to time of changes in the situation and to make recommendations for the purpose of increasingly implementing and inproving malpractice defense, and be it further

"Resolved, that upon direction by this House or the Council our audit be made by an insurance actuary or actuaries"

The Report was accepted and the Resolution adopted

We are now in regular SPEAKER ANDRESEN session

Section 105 (See 17)

Report of Reference Committee on Reports of President

DR PHILLIP D ALLEN, New York Your Reference Committee sympathizes with the expressions of the President regarding the deaths of Doctors Hale,

Dwight, Flynn, and Sullivan

We agree with his suggestion that plans should be promulgated to the end that the work of our officers should be made less burdensome Your Reference Committee recommends that plans be made to accomplish this by subdividing the tasks of, or by increasing the number of, elective officers Your President has in his supplementary report discussed this situation as it relates to your Board of Trustees and has presented amendments to the Constitution to effect these changes With this your Committee heartily concurs

Your Reference Committee specifically calls attention to that part of the President's report wherein he urges the House of Delegates to give serious attention to the matter of increasing the

The remainder of the report consists of a survey of the various activities of our Society and requires no recommendations

In his supplementary report our President discusses the merits of two bills now in Congress, having for their objective the centralization of all health activities of the Federal Government Your Reference Committee feels that it is not its function to make any recommendations in reference to this legislation, as it is being considered by another Reference Committee

The President bids us to be forward-looking in our program and not to wait for things to happen We particularly stress his statements that "Whatever is best for the public must be our aim," and "Our action must be both progressive and aggressive "

We heartily concur with his appeal to arouse the interest of individual physicians and to revitalize our county societies, and his statement that it is of utmost importance for each individual to take it upon himself to make his county society a vital force

In conclusion, your Reference Committee feels deeply impressed by the wholehearted and efficient manner in which our President has responded to the increased responsibilities which were so suddenly forced upon him We feel certain that his assurance that he will do his best to carry out the duties placed on his shoulders and will prove himself worthy of our confidence is no idle promise

I move the acceptance of this report

The motion was seconded, and as there was no discussion, it was put to a vote, and was unanimously carried

## FORTY FIRST ANNUAL MEETINGS of the DISTRICT BRANCHES of the

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### PROGRAMS.

Third District Branch Thursday October 16 1947 Grossinger Hotel Ferndale New York

### Morning Session

11 00 a M.—Symposium on Thyroid 'Malignant Lesions of the Thyroid John C McClintock, M D assistant professor of surgery Albany Medical College "The Diagnosis and Treatment of Diseases of the

Thyroid Donald Guthrio M D Stanley D Conklin, M D

Guthrie Clinic Robert Packer Hospital Sayre Pennavlvania

1 00 r.u —Luncheon

Address by Louis H Bauer M D President, Medical Society of the State of New York

## Afternoon Session

2 30 r.n.— Streptomycin and Tuberculesis William H Stearns M D instructor in medicine College of Physicians and Surgeons, Columbia University associate visiting physician chest service Bellevue Hospital BCG Immunization

Konrad Birkhaug, M.D., Division of Laboratories and Research, New York State Department of Health, Albany

\* Ferndale is on Route 17 Just outside of Liberty New York.

"The Treatment of Common Skin Diseases

Timothy J Riordan M.D., associate chinical professor of dermatology and syphilology New ork University College of Medicine

Ladies will join the members of the District Branch for luncheon.

## Officers-Third District Branch

President Frederic W Holcomb M.DLingston 1st Vice-President Harry Golembe M.D Liberty 2nd Vice-President William C Rausch, M.D. Al-

bany Secretary Donald R. Lyon M D , Middle-

burgh Treasurer William M Rapp, M D Cat

Presidents of Component County Societies Homer L. Nelms M.D Albany Elah C Bliss, M.D. Hudson Benjamin Miller M.D. East Dur

Rensselaer

Francis J Fagan, M D , Troy John H Wadsworth, M D , Cobleskill Ralph S Breakey, M.D Monticello Douw S Mayers M.D Kingston Schoharie

R.

Monteith

## First District Branch Thursday October 30 1947 Veterans Administration Hospital 130 W Kingsbridge Road

Albany

Greene

Sullivan

Ulster

Columbia

## Bronx, New York

Morning Session 9 00-10 00 A.M.—Operative Surgical Clinic 10 00-12 00 A.M.—Medical Clinic with Presentation of Cases

12 00 NOON-Buffet Luncheon Panel Discussion—Public Relations Louis H. Bauer, M.D Moderator

Mr Dwight Anderson Stephen R. Monteith M D M Renfrew Bradner M D

## Afternoon Session

2 00-4 00 P M -- Panel Discussion-- Treatment in Hypertensive Renal Disease Scott Lord Smith, M D Mod erator

Arthur M Fishberg, M D Herbert Chasis M D Henry Barnett, M D Bronson S Ray M D

## Officers-First District Branch

Prosident Harold F Morrison, M.D. Tuxedo Park

First Vice-President Stephen Second Vice-President

Stephen 1...
M.D. Nyaok
William Crawford White
M.D. New York City
I. J. Landsman, M.D. Secretary

Bronx Henry W Miller M D Treasurer

Presidents of Component County Societies

X Samuel Welskopf M D Bronx

Shoss James J Toomey M D Pough-Bronx Dutchess

keepsie Harold B Davidson M.D New New York

York City William J Hicks M.D Middle-Orange

Putnam Garrett W Vink, M.D., C Stanley C Pettit M D Carmel Richmond

Rockland E. Hall Kline, M.D., Nyack William G. Childress M.D., Val Westchester halla

George

## NECROLOGY

James Manning Bernhard, MD, of Walden, died on August 24 at the age of 68 He was a graduate of Syracuse University, College of Medicine, in 1906 During World War II he was medical examiner for the Town of Montgomery draft He was a member of the New York State and Orange County medical societies and of the

American Medical Association

American Medical Association
William T Flanigan, MD, 51, of Watervliet,
died on August 18 In 1922 Dr Flanigan was
graduated from the Syracuse University, College
of Medicine, and served his internship at City
Hospital in New York City From 1924 until 1927
he was director of the Bender Laboratory in Albany, leaving there to establish his practice in Water-vliet. He was a member of the Albany County and New York State medical societies and the American Medical Association

Louis Ammon Gould, MD, of Syracuse, died on August 1 He was 71 years of age Dr Gould was a member of the faculty of the College of Medicine, Syracuse University, until his retirement three years ago A graduate of Syracuse Univer-sity, College of Medicine, in 1904, he practiced in Schenectady until moving to Syracuse in 1918 During the war he served as a school physician and welfare department physician, retiring from the welfare post on July 1 He was a member of the American Medical Association, the Syracuse Academy of Medicine, and the Onondaga County and New York State medical societies

Anthony F De Graffenried, M D, 62, of Bayside and formerly of Flushing, died on August 9 Graffenried, a retired surgeon, was a member of the surgical staff of Flushing Hospital for fifteen years He was graduated from the University of Louisville Medical School in 1911 and began the practice of medicine and surgery in Queens in 1915. He was a member of the Queens County Medical Society and the American Medical Association

Clement A Jarka, M D, of St Albans, Queens, died September 1 at the age of 51 Dr Jarka received his medical degree from Cornell University Medical College, in 1922 He was a member of the Queens County and New York State medical societies and the American Medical Association.

societies and the American Medical Association. He was formerly assistant physician at St Catherine's Hospital, Brooklyn
William H Johnson, M D, 59, of Buffalo, died on August 16 A graduate of the University of Buffalo, School of Medicine, in 1913, Dr Johnson served as a captain in the Medical Corps during World War I Until his retirement three years ago, Dr Johnson was medical officer for the New York Dr Johnson was medical officer for the New York Telephone Company and consulting surgeon at Emergency Hospital in Buffalo He was a member of the American Medical Association, the New York State and Eric County medical societies, the Buffalo Surgical Society, the Academy of Medicine, the Association of Industrial Surgeons, and the American Public Health Association He was also a fellow of the American College of Surgeons

Walter Falke Jones, M.D., 61, of New York City, died on September 9 Dr Jones received his medical degree from Johns Hopkins Medical School in 1914 and interned at French Hospital, New York City He served in the Army Medical Corps dur-ing the first World War In 1916 and 1917 he was adjunct attending surgeon at the Hudson Street

Hospital and in 1916 a fellow in pathology at Cor-Since 1926 Dr Jones had been nell University associated with the Hospital for the Relief of the Ruptured and Crippled, New York City He was also associate surgeon at Manhattan General Hospital, medical director of the Globe, Royal, and Eagle Indemnity companies, and medical adviser to the American Bank Note Company He was a fellow of the American College of Surgeons and a member of the American Medical Association, and

the New York State and County medical societies
Jacob D Khodoff, M D, 70, New York City,
died August 7 He was graduated from New York

University, College of Medicine in 1899

Joseph B L'Episcopo, M D, 57, Brooklyn, died on September 6 He was chief orthopedic surgeon at the Long Island College Hospital and, for the past seven years, professor of bone and joint surgery at the college He was director of orthopedic surgery at Kings County Hospital and chief of the medical staff at the House of St Giles the Cripple was also on the staffs of Bushwick and Peck Memorial hospitals, Brooklyn. Dr L'Episcopo was graduated from the Long Island College of Medicine in 1914 During World War I he served as an orthopedic surgeon with the Army, and during World War II he was consultant in orthopedic surgery to Selective Service He was a fellow of the American Academy of Orthopedic Surgeons and the American Orthopedic Society, a member of the New York State and Kings County medical societies and the American Medical Association

Evelyn E Lowe, M D, 80, of Brooklyn, died on August 2 She was engaged in the general practice of medicine in Brooklyn for more than forty years In 1897 Dr Lowe was graduated from the Boston University Medical School She was on

the medical staff of Prospect Heights Hospital
Robert Daniel Manning, M D, 60, of Peekskill,
died on August 16 He was graduated from the
Albany Medical College in 1908 and served his internship in the Samaritan Hospital in Troy 1909 he had practiced medicine in Peckskill, serving two terms as president of the medical staff of the Peekskill Hospital For twenty-three years he was company physician at the Peekskill plant of Standard Brands, Inc

Charles L Myers, MD, of Albany, died on September 1 at the age of 92 He was graduated from Albany Medical College in 1895 and for more than fifty years was a practicing physician in Al-

bany

David Joseph O'Connor, M D, of Croghan, died on July 15 at the age of 42 He was graduated from the University of Toronto Medical College in 1930 A member of the staff of Lewis County General Hospital in Lowville, Dr O'Connor was also a member of the New York State and Lewis County medical securities and the American Medical Association of the American Medical Association and the American Medical Association of the American Medical Association of the American Medical Association and the American Medical Association of the Medical Association and the American Medical Association of the Medical College in the Medical medical societies and the American Medical Asso-

Eugene T O'Connor, M D, of Tarrytown, died on August 8 He was 66 years old He was graduated from Fordham University, College of Medicine, in 1914 A member of the staff of the Veterans Hospital on Kingsbridge Road, Dr O'Connor had been connected with the U S Veterans Rureau since World Worl ans Bureau since World War I

James Timothy Park, M D, of Hudson Falls, died on August 9 at the age of 84 A graduate of Albany

Medical College in 1894, Dr Park practiced medicine in Hudson Falls since 1895 He was a member of the consulting staff of Glens Falls Hospital and a member of the State Medical Society and the

American Medical Association

James Chambers Pryor, M.D., 76, of Brooklyn, died on September 8. In 1895 Dr Pryor, who was a rear admiral (retired) in the U.S. Navy, received his medical degree from Vanderbilt University Two years later he entered the Navy as a surgeon. He served as medical side to President Theodore Roosevelt after active service in the Navy in the war with Spain While head of the department of hygiene at the Naval Medical School in Washington from 1917 to 1920 and professor of proventive medicine at George Washington University from 1917 to 1910 Admiral Pryor published the best known of his medical writings, Naval Hygiens From 1925 until 1928 Admiral Pryor commanded US Naval hospitals at Yokohama, Japan, Pensa cola, Florida Hampton Rhodes Virginia, and at the U.S. Naval Modical School He was medical officer and head of the department of hygiene at Annapolis from 1928 until 1931 He retired on April 1 1935

Frederick Cornwall Reed, M.D., 72 of Schenec tady, died on July 21 He was graduated from Albany Medical College in 1902 and served his in ternship at the Ellis Hospital in Schenectady was a member of the American Medical Association and the New York State and the Albany County

medical societies.

Norman Brown Saunders, M.D., of Larchmont formerly of Mount Vernon, died in July at the age of 72 He was graduated from the College of Physicians and Surgeons Columbia University, in 1900 Dr Saunders was neurologist and clinical psy chiatrist at New York Hospital neurologist at the New Rochelle Hospital, and consultant in neurology at Grasslands Hospital in Valhalla.

Jesse Schepps, M.D., 50 of Brooklyn died in August He was graduated in 1920 from New York University School of Medicine Dr Schepps 1 ork University School of Medicine 1.7 Schopps was physician in-charge of physical medicine at Kings County Hospital, director of physical medi-cine Israel Zion Hospital associate in physical medicine at the Jewish Hospital for Chronic Diseases, and adjunct at Both Moses Hospital, all in Brooklyn. He was a fellow of the New York Diabetes Association and the American Medical Association, a member of the American Congress of Physical Medicine the New York and Brooklyn societies of physical medicine, the New York State and Kings County medical societies, and the New York Heart Association

George Haines Treadwell, M.D., 90 of Brooklyn, died on August 2. He had practiced medicine in Brooklyn for forty five years when he retired in Dr Treadwell was graduated from the College of Physicians and Surgeons, Columbia Univer sity, in 1885 and soon after was appointed to the chair of children's diseases at the Brooklyn City Dispensary He had been a member of the Kings County Medical Society since 1883 and in 1903 and

1004 was its president.

Stephen L. Walczak, M.D., 40 of Buffalo, died on August 11 He received his medical degree from the University of Buffalo, School of Medicine in 1921, and until 1924 was on the staff of City Hospital and Fifth Avenue Hospital, New York City returning to Buffalo in 1925 Dr. Walczek was director of gaduate education at Millard Fill more Hospital, Buffalo president of the hospital staff from 1914 to 1916 and chief of its division of surgery for the next two years He was an attending surgeon at Meyor Memorial Hospital, Buffalo, consulting surgeon at the J N Adam Memorial Hospital in Perrysburg and consulting surgeon for thyroid diseases at Mercy Hospital Buffalo He was instructor in surgery at the University of Buffalo School of Medicino. Interested in public health, Dr Walczak was senior surgeon in the US Public Health Reserve from 1942 to 1947 He served on the Buffalo Board of Health from 1938 to 1941 He was a diplomate of the American Board of Surgery and a member of the American Medical Association, the New York State and Erie County medical

oscar Wald, M.D., 59, of Brooklyn, died on August 17 A specialist in internal medicine he served in the Navy Medical Corps as a commander in both the Atlantic and Pacific thaters during World War II. Has according to the Navy Medical Corps as a commander in both the Atlantic and Pacific theaters during World War II. Has according to the Navy Medical Corps as a commander in both the Atlantic and Pacific theaters during World War II. Has according to the Navy Medical Corps and the Navy Medical Society of the Navy Medical Corps and World War II He received his medical degree from

World War II. He received his include a uegies from Fordham University College of Medicine in 1914
Edwin B Wilson, M.D., of Brooklyn, died on August 3 at the age of 69. He had practiced medicine and surgery in Brooklyn for thirty five years prior to his retirement in 1914. A graduate of Albany Medical College in 1907 Dr. Wilson was not be stelled of Convertigated Caledonian and St. on the staffs of Concy Island, Caledonian, and St. Marys hospitals all in Brocklyn. He was a mem ber of the Kings County and New York State medical scoletics and the American Medical Association.

### ANNOUNCEMENT

Participating physicians are urged to send in treatment authorization Form NY10-104 promptly on completion of treatment as authorized, in order to expedite payment for services rendered. It is not necessary nor desirable to wait until the first of the month to submit such reports. Presentation of this form within thirty days will be appreciated

If for any reason authorized services have not been given, or will not be given physicians are requested to return authorization form promptly for cancella-tion so that funds encumbered may be used for other authorization. For any services completed prior to July 1 1947 authorization forms should be submitted without further delay

Participating physicians are again requested to make complete reports on patient s condition and response to treatment. If the space on Form NY10-104 does not seem sufficient additional data may be presented on physician s own letterhead in duplicate

> GEO HUNTER O KANE, M.D. Coordinator Veterans Medical Service Plan of New York Inc.

## ABSTRACT OF MINUTES OF THE COUNCIL OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

T ITS meeting on September 11, 1947, the Council considered various matters, taking final action or directing further study and reports, as indicated under the following headings

## Secretary's Report

Remission of State Assessments —The remission of State assessments was voted on account of service with the armed forces for 20 members for 1947, and 75 for 1946, also on account of illness for Drs Anna M Ralston, Paul E Wesenberg, and F Ward Renfrew The refunding of dues of one member was authorized

Meetings —At the request of Dr T P Murdock. chairman of the Committee on Nursing of the House of Delegates of the American Medical Association, your Secretary took the liberty of placing a room at

his disposal for a meeting on September 3

On July 28 to 30, the 43rd Annual State Health Conference of the New York State Department of Health was attended at Saratoga Springs by Drs Bauer, Winslow, Mitchell, Hannon, Anderton, and Messrs Walsh and Cook of the Public Relations Bureau One of the best features of the program was an address by President Louis H. Bauer

During his holiday, your Secretary visited the towns of Honeoye, Dexter, and Parishville in order to help these communities obtain a local physician

Directory -The Publication Committee will report about distribution of the 1947 Medical Directory of New York, New Jersey and Connecticut, which is almost completed As this is our first directory in five years, quite a few mistakes have occurred. A few have been due to clerical errors However, most of the incorrect listings have occurred because proper information was received after the deadline for going to press, October 1, 1946 The report was accepted

Communications.—1 Letter dated August 15, 1947, from John W Brownlee, executive secretary, Vermont State Medical Society, requesting the name of the delegate (or delegates) to the annual meeting of the Vermont State Medical Society,

on October 1, 2, and 3

It was voted that one or two delegates be sent 2 Letter dated May 13, 1947, from Dr E S Platt, Auburn, in regard to not holding reservation at Hotel Buffalo at the time of the 1947 Annual Meeting, was brought to the attention of the Council

Letter dated July 9, 1947, from Dr R L

Yeager, secretary, the Medical Society of the County of Rockland, was read by the Secretary
"The following resolution was adopted by the Rockland County Medical Society at its June meeting, held June 25, 1947 A copy of this resolution was sent to the secretaries of Orange, Putnam, Dutchess, and Sullivan counties for endorsement with a request that they take action upon a similar resolution

"Resolved, Many problems arise in the component county societies of the Medical Society of the State of New York The work of each county society is increasing tremendously. Close contact of various societies with the State Society is becoming increasingly necessary in order to produce concerted action on many problems appears that through development of the dis-

trict branches an opportunity is offered for closer amalgamation of effort on the part of contiguous counties which have common political and public relations problems

"Therefore, the Medical Society of the County of Rockland requests the Council of the Medical Society of the State of New York to undertake a study of the present makeup of the district branches to the end that a redistribution of counties within each district branch be made and other steps taken whereby the district branches may become organizational units to strengthen

the unification and solidification of the State Society"

It was voted that this be referred to the Planning Committee

Letters dated June 12 and September 2, 1947, from Dr Charles Gordon Heyd, president, Physicians' Home, in regard to the nomination of directors for Physicians' Home, were presented by the Secretary, and

It was voted to nominate the following David M Freudenthal, Dr B A Goodman, Mrs Edmund A Griffin, Dr David J Kaliski, Dr Luther MacKenzie, Dr Ada Chree Reid, Dr Shepard Krech, Dr Beekman J Delatour, Dr Irving Wright, Dr Donald B Armstrong, Dr Cornelius Rhodes, Dr L F Rainsford (Rye), Dr Thomas M Brennan (Brocklyn) Dr Fordwea B St John. M Brennan (Brooklyn), Dr Fordyce B St John, Dr A W M Marino (Brooklyn), Dr. Harry Imboden, Dr Dever Byard, Dr F W Holcomb (Kingston), Dr E C Jessup (Roslyn), Dr Tasker Howard (Brooklyn) (Residences are New York City, unless otherwise noted )

A letter from Dr A. Carl Hofmann, treasurer of the Onondaga County Medical Society, was received, requesting advice concerning dues for new applicants during the remainder of the year, since, according to the State Constitution, dues and assessments of a member elected or reinstated after October 1 shall be credited to the succeeding year

The Council voted that the interpretation of the above would be that the assessment for each member elected after October 1, would be \$15, the House of Delegates having prescribed this as the State Society assessment for the year 1948

Treasurer's Report was Accepted

## Report of Executive Officer

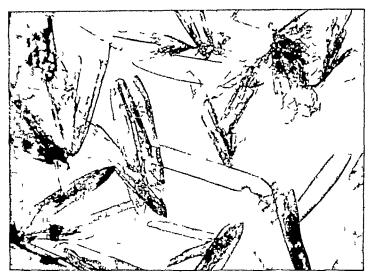
Dr Robert Hannon reported that since the last meeting of the Council he had attended various meetings of the State Health Department and county societies and committee meetings of the Society, that at the present time all arrangements for all District Branch meetings had been completed, that a few programs had already been printed, and sent to the New York office for distribution

## Activities of Committees

Subcommittee on Cult Practice —Dr Maurice J

Dattelbaum, chairman, reported progress
Constitution and Bylaws.—The Council voted to approve the changes requested by the Medical Society of the County of Ontario in their bylaws relating to membership

[Continued on page 2222



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[Continued from page 2220]

Committee on Economics —The following report of the Director of the Bureau of Medical Care was submitted

June 22, 1947 Mr George P Farrell interviewed the directors of all six medical care plans in New York State regarding development of a special folder to be used for the promotion of medical care insurance by each plan in its respective area plans have indicated their willingness to cooperate

The folder will consist of four pages, the front page to include the name and address of each local plan, and the text for the two inside pages to be furnished by each plan, describing benefits offered and such other information as the plans may wish to The back page will contain facts on the progress of all plans throughout the State for the six months ending June 30, 1947, and will be compiled by the Bureau Each plan will bear the cost of the folders used Pamphlets will be distributed to all doctors throughout the State to acquaint them further with the progress of nonprofit voluntary insurance plans in the State

July 17, 1947 Mr Farrell spoke before the Vermont State Health Council at Montpelier on

"The Importance of Medical Care Plans in a State Health Program"

July 30, 1947: The Director contacted Dr Luther Thomas, president of the Steuben County Medical Society, concerning action which had been taken by that Society in connection with affiliation in the Central New York Plan, Syracuse The Steuben County Medical Society is the only Society in the plan's operating area which has not taken official action Dr Thomas referred Mr Farrell to Dr Richard O'Brien, chairman of the Legislative Committee, and he advised that he would bring the matter to the attention of the Society at the earliest

August 6, 1947 Mr Farrell received a letter from Mr Frank Smith, director of Associated Medical Care Plans, stating that the Executive Committee of AMCP had appointed Mr Farrell a member of its new Committee on Research Studies Mr Jay Ketchum, executive director of Michigan Medical Service, is chairman of the new committee, and Dr Frank G Dickinson, director of the Bureau of Medical Economic Research of the AMA, will assist the committee in an advisory capacity

Mr Farrell has written Dr A H Aaron, chairman of the Subcommittee on Medical Expense Insurance, regarding acceptance of this appointment. and Dr Aaron personally feels very strongly in favor of acceptance and recommends its approval by the proper officials of the State Society On the advice of Dr Aaron and Dr Anderton, Mr Farrell attended the first meeting of this Committee in Chicago, on

September 4 and 5, 1947

It was voted that acceptance of this appointment be

approved
Mr Farrell made a progress report on the New
York State Medical Care Plans for the six months ending June 30, 1947, as follows Membership as of June 30, 1947, was 860,703, which represents an increase during the first six months of 260,070 This increase exceeded the same period of 1946 by 104,356 participants, or 66 6 per cent

Benefits to participants for the first six months of 1947 were \$1,460,770 During the same period of 1946, benefits to participants were \$684,797 The increase in benefits to participants during the first six months of 1947 was \$775,973, or 113 3 per cent Particular attention is called to the increase in

claim incidence over the previous quarter ending March 31, 1947, in practically all plans

Subcommittee on Public Medical Care -Dr Christopher Wood, chairman, reported verbally as follows "Just two points First, you will recall that the first schedule of reimbursable charges of the Welfare Department remains in effect through December of this year It is anticipated that probably prior to that we will begin to seek upward revision of the fee schedule, and if possible to achieve the same scale as workmen's compensation

"Second, we continue to receive complaints about the payment of physicians' fees directly to the patient You will recall that, although I personally felt that was a good method, last year, or the year before, the House of Delegates went on record favoring the payment for physicians' services directly to the physician Payment to the patient is still a requirement of the US Social Security Board, and the State, as far as we have been able to determine, has no recourse but to follow that requirement. It is no recourse but to follow that requirement rather hoped that in the coming year some revision may be had on that I don't think they will rescind it, but some revision of that requirement may be obtained so physicians in New York State can be paid directly for their services"

Committee on Ethics -The question of ethics, in connection with an advertisement by Dr Thomas H Halsted on page 1532 in the July 1 issue of the Journal, was raised Dr Bauer also brought to the attention of the Council the fact that the New YORK STATE JOURNAL OF MEDICINE WAS being criticized by the A.M.A for some advertisements it

was carrying After discussion.

It was voted to refer this to the Publication Committee, together with an excerpt of Dr Bauer's remarks

Malpractice Insurance and Defense Board —Dr Thomas M D'Angelo, chairman of the Board, presented a report regarding the operation of the

Group Plan of Malpractice Insurance

Committee on Office Administration and Policies —The Committee submitted a report on routine matters, and is continuing its studies in regard to improving the management and policies of the running of the office The removal of the Society's offices in the near future to the seventh floor of the building was discussed

Planning Committee for Medical Policies —Dr J Stanley Kenney, chairman, submitted the follow-"Subject Report on the Group Hosing report

pital Council, Ltd

"Early in the spring of 1947 a group of physicians from metropolitan New York began a series of meetings as a discussion group to debate and study problems encountered in group medical practice, in which in some measure they were all engaged After several meetings they decided to expand the group and invitations were forwarded to a number of others interested in this type of practice, not only in the New York area but generally over the eastern section of the United States

"At this time (May 8) the Medical Society of the State of New York was asked to send a representa-Because of the fact that the Planning Committee for Medical Policies is engaged in studying this problem for the Society, the President, Dr Bauer, asked me to attend the meetings in the capacity of observer and in due course to make a re-

port to the Council

'I have been present, up to now, at four meetings, the most recent of which was on September 4

[Continued on page 2224]

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Short

(Kindly pri 1 name and address)

[Continued from page 2222]

group has now incorporated and is known as The Group Practice Council, Limited The incorporators are Drs Marshall Brown, Edwin J Grace, Harry J Johnson, Lester C Spier, and Louis R Walberg The legal counsel for this Board is Reed B Dawson, Esq You will recall that Mr Dawson is and has been for many years the counsel for the Medical Society of the County of New York. Some twelve to fifteen doctors have regularly attended these conferences They represent a pretty fair cross section of the various medical groups now active in the Included are such group metropolitan area services as industrial medicine, hospital groups, insurance groups, the university groups now forming, private group clinics, Group Associates (the Summit, New Jersey, group), the Life Extension Examiners, and the Hospital Insurance Plan of Greater New York, better known as HIP, and a number of others

"The aims and purposes of the Group Practice Council are set forth in Part 2 of the Certificate of

Incorporation as follows

"To collect, gather, correlate, and study facts, data, and information relating to all phases of the practice of medicine, both in the metropolitan area of the City of New York and elsewhere, including foreign countries, by two or more physicians or surgeons acting in concert either as copartners, as organized groups, as hospital staffs, as clinics or dispensaries, or otherwise in any manner whatsoever, and to publish and disseminate such facts, data, and information, together with the results of studies made thereon, to interested persons and to the public generally, to foster and promote high standards in the practice of medicine by physicians or surgeons in concert as aforesaid, and to establish standards of practice applicable to the several different types of such practice in concert, and to grant certificates to physicians and surgeons so practicing in concert who shall meet and comply with the standards so established by this corporation, and in connection therewith to own, operate, and maintain such offices and other facilities as may be necessary and proper in order to carry out the foregoing purposes, and in the furtherance of such purposes to conduct its operations exclusively for charitable, scientific, and educational purposes, with no part of the net earnings of the corporation enuring to the benefit of any private member or individual, but the corporation shall not have or exercise any of the special powers or purposes set forth in any of the provisions of Section 11 of the Membership Corporations Law, nor shall it carry on propaganda or otherwise attempt to influence legisla-tion. The "educational purposes" as used herein shall be limited to the publication and dissemination of facts, data, and information collected and gathered by the corporation as hereinabove provided, together with the results of studies made thereon, and the corporation specifically shall not have any purpose for which a corporation may be chartered by the Regents of The University of the State of New York

"The territory in which its operations are principally to be conducted is the metropolitan area of New York City and expansion on a national scale as soon as practicable - in fact invitations are about to go out to representative large groups such as the Lahey Clinic, the Cleveland Clinic, the Sayre Clinic, the Mayo Clinic, etc

In my judgment there seems to be no reasonable criticism of these aims and purposes as set forth

did take exception and interposed objection to that clause referring to the granting of certificates to 'physicians and surgeons so practicing in concert who shall meet and comply with the standards so established by this corporation' I felt this might likely be in conflict with and encroach upon the proper rights and privileges of the county medical societies, and cautioned that organized medicine would be concerned and probably would not go along if this implied any infringement on these rights and privileges However, the meaning of this clause was clarified for me satisfactorily The best minds among this group are distinctly opposed to any conflict with organized medicine. They are idealistic and uphold high ethical principles and they propose to work entirely within the framework of

organized medicine, and desire its full collaboration "As I understand their objective at present, it is to set up a Board or Council which will bear much the same relation to medical practice that the national specialty boards now enjoy, in other words, they are seeking to clean their own house, to adduce and set up standards for qualification and raise the level of group practice to such a plane as will command the confidence and respect of both the profession and the public Their inclusion of representatives of such groups in their current setup as organized medicine is not in full accord with and which it regards with justifiable suspicion is for the purpose of bringing squarely before them what will be expected and demanded of group practice every-

"Up to now all discussions have been along ethical lines and no reference has been made to financial support, fees, etc This group is deeply interested in the resolutions on group practice presented to the House of Delegates of both the State Society and the A M A at their most recent meetings Dr Spier was in Atlantic City and appeared before the Reference Committee, which referred the A M A. resolution to the Trustees with the recommendation that it be studied by the Office of Medical Economic Research, the Judicial Council, and the Council on Medical Service

"I believe our State Society at this time can with interest and profit follow the activities and progress of this Group Council, Limited, and, while not taking any formal action at present, should continue to have a representative attend their meetings"

Committee on Public Health and Education — Dr O W H Mitchell, chairman, reported as fol-

June 27, 1947 In Syracuse, attended a meeting of the executive committee and presidents of the component county societies of the Fifth District

July 17, 1947 In New York City, attended a meeting of the Cult Practice Subcommittee of the Committee on Legislation

July 29 and 30, 1947 In Saratoga, attended the Annual Conference of Health Officers

August 15, 1947 In New York City, attended a meeting of the Council Committee on Public Health and Education and the Subcommittee on Cancer Also present at this conference were some of the officers of the Medical Society of the State of New York, the Commissioner of Health, the Deputy Commissioner, and the Director of Cancer Control of

the New York State Department of Health September 10, 1947 Attended the meeting of the Council Committee on Public Health and Education and the newly appointed Subcommittee on Geri-

[Continued on page 2226]





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# Elixir Gabail

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atrics held at the home of the chairman of the Subcommittee on Geriatrics, Dr Stephen R. Monteith, Nyack.

September 16, 1947 A meeting of the Council Committee on Public Health and Education and the Subcommittee on Physical Medicine was held in New York City Invited to attend this conference were some of the officers of the Medical Society of the State of New York and representatives of the State Departments of Health and Education

Postgraduate Education -Instruction has been arranged for and will be given in the near future in the following counties Broome, Cayuga, Cortland, Jefferson, Monroe, Ontario, Orange, Oswego, and

Tompkins

A Regional Teaching Evening was arranged for the Otsego County Medical Society to be given on September 10, 1947 Invited to attend this meeting were the physicians of Otsego and Delaware county medical societies

Requests for instruction have been received from Clinton, Sullivan, and Warren county medical societies and arrangements are being completed

During the summer months, arrangements were completed for instruction to be presented in Madison

and Suffolk county medical societies

Because the 1946-1947 Course Outline Book was received so late from the printer last year, the Committee plans to distribute a supplement for 1947-1948

BCG Advisory Committee —A meeting has been arranged for the BCG Advisory Committee

Committee on Public Relations -Dr Floyd S Winslow, chairman, submitted the following re-port "News releases concerning events sponsored by the Committee on Public Health and Education were sent to the following counties Cayuga, Madison, Ontario, Oswego, Otsego, Rockland, Tompkins. and Warren

"A news release on the Rocky Mountain spotted fever symposium which appeared in the July 15 issue of the New York State Journal of Medicine was mailed to wire services, daily and weekly newspapers in New York City and Suffolk County

"Mr Dwight Anderson, Mr Edgar L Cook, and Mr Thomas Walsh attended a meeting of the Subcommittee on Cult Practices of the Legislative Com-

mittee at the Hotel Commodore, July 17

"Mr Cook and Mr Walsh attended the 43rd Annual State Health Department Conference at Saratoga, July 28 to 31

"Approximately 9,000 reprints of Dr Bauer's radio talk, 'Do We Need Compulsory National Health Insurance?" delivered over Station CBS 'People's Platform,' May 25, and 2,600 copies of the July issue of The Distaff were maked. Mr. Cook gave editorial assistance and advice to Mrs Sanborn, editor

"Mr Cook continued work on the fifty-year doctor pamphlet memorializing the physicians who have practiced medicine for fifty years or more search for a handbook on the activities of the State Society is being conducted under the supervision of of Mr Cook. Mr Walsh and Mr Cook conferred with Mr Anderson August 13, on the fall schedule of

activities

"In efforts to curtail unlicensed schools and illegal medical practice, Mr Walsh maintained contact with the Department of Education, members of the Board of Regents, Office of the Attorney-General, the New York County District Attorney's office, the

State Society's legal counsel, and members of county societies

"Mr Walsh and Mr Cook attended a special meeting of the Legislative Committee on August 6 Mr Walsh reported the currrent progress of the Wicks Committee and studied the advisability of using injunctive proceedings to eliminate illegal medical practice Mr Walsh and Mr Anderson discussed the early implementation of your committee report on the establishment of a Speakers' Service Mr Walsh continued his work on a report to the Council on cult practices "

Publication Committee —In the absence of the chairman, Dr Laurance D Redway presented the following report "The Committee met at the Society's Offices on Tuesday, September 2, 1947, at 2 PM Dr Redway was instructed to take over as Acting Managing Editor of the JOURNAL in Dr Kosmak's absence during the month of September

"Miss Alvina R. Lewis will replace Miss Willma Simmons as Technical Editor of the Journal as of

November 1

"The Committee is pleased to report that the September 1 issue of the Journal will have reached the membership within a few days of the normal schedule It is hoped that future issues will be mailed exactly on schedule

"The Business Manager was instructed to try to obtain increased paper, even if it is necessary to pay as much as double the mill price, so that an additional form may be added to each issue of the

JOURNAL as soon as possible

"Editorial comment will be made in the October 15 issue of the Journal on Dr Louis H Bauer's forthcoming valuable book, Private Enterprise or Government in Medicine, to be published by Charles

Thomas, Inc.

"The 1947 Directory has been delivered to 16,000 members and 1,654 nonmembers as of August 29, a total of 17,654, delivery of all Directories is expected by September 15 Plans have already been made to commence compilation of the 1948 Directory immediately following the delivery of the last copies of the 1947 issue Compilation will require six to eight months depending on available space and competency of personnel It is planned to add running heads in the 1948 Directory in order that listings for New York, New Jersey, and Connecticut may be more easily found on opening the book."

It was voted that the report be approved

Liaison with the Veterans Administration -Dr Anderton read the following letter from Dr Herbert H Bauckus

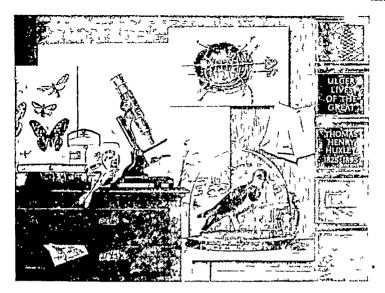
"Dear Dr Anderton,

"I have your kind invitation to attend this meeting of the Council but by this letter I think I may report to you the information necessary at this time

"Our coordinators are working satisfactorily at the branches in New York, Albany, Syracuse, and Buffalo No coordinator has been appointed for the proposed branch in Brooklyn I am awaiting word from Dr Lane on the time for this appointment

"During the summer the coordinators were again asked to report on instances of questionable prac-I am pleased to say that no serious violations are reported although there are two cases pending in which the attending physician, by prior arrangement with the patient, charged an additional fee besides our regular scheduled veteran's fee I think this is not good practice but I do not find the records specifically showing orders against this

[Continued on page 2228]



# Was it Huxley's Peptic Ulcer that always returned in the fall?



Thomas Henry Huxley was Darwin a staunchest ally in the dramatic fight between science and fundamentalism. But his writings platform appearances and public de

bates brought on painful attacks of dys

Even though he retured at 59 his ulcer symptoms, returned to plague him each fall Robinson, M. E., The Ulcer Life, Chairs 3,480-493 (Oct.) 1914.



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[Continued from page 2226]

the physician's bill and report calls for no statement

regarding this item
"We have suspended a few men for charging for time not actually spent We have had a request from the Veterans Administration for suspension or removal in one case that is being investigated

"There has been a marked reduction in the amount of authorization granted This especially applies to hospitalization, and I should like to say that except in cases of acute emergency, medical or surgical care requiring hospitalization apparently is not available under the private practice plan I have protested this to Colonel Harding in Washington and talked with him by telephone last week. He stated that there has been a shortage of funds and he hopes this will be corrected He knew that there were many problems requiring further study but suggested that we postpone a meeting with him until the American Medical Association Committee has its meeting

early in November
"I therefore feel that most of our negotiations
"I therefore feel that most of our negotiations taken must wait for this date, especially on matters taken

care of on a national basis

"There have been some changes in the methods of procedure in our own plan in New York State have communicated with the Acting Branch Medical Director, Dr. A. M. Kleinman, and objected to the removal from the active lists of physicians who were working part-time for the Veterans Administration There have been objections on the part of the Veterans Administration to physicians receiving an amount of money in maximum of \$6,000 per year There has been added an additional amount of paper work which, however, may be only temporary

"All of these matters and many others will be brought before the Board of Directors at a meeting early in October Following this meeting I shall be able to make a more comprehensive report to the Council"

Committee on Woman's Auxiliary —Dr Fenwick Beekman, chairman, reported there was a meeting held at the Barclay Hotel on September 9 at which Dr Elton Dickson and Dr Beekman met with the They outlined officers of the Woman's Auxiliary and discussed very fully their program for the year It is a good, promising program.

Committee on Workmen's Compensation —Dr J Stanley Kenney, chairman, submitted the follow-

ing report

Reporting of Compensation Cases The issuance of new rules covering the reporting of compensation cases by the Chairman of the Workmen's Compensation Board has created a bit of confusion in various parts of the State in regard to the forms to be used for closing cases On August 28, an inquiry was directed to the Chairman of the Workmen's Compensation Board asking for a clarification of her report dated May 7, 1947 As soon as a reply is received, the membership will be informed

Along these lines an inquiry was received from one of the members of the Workmen's Compensation Committee as to the necessity of filing progress reports in protracted cases where the physician sees the patient at intervals of more than one or two months The present rule requires a report every It was brought to the attention of the three weeks Chairman that under these circumstances it was an unnecessary burden on the physician to report every three weeks where a case is not seen as frequently as

Free Choice of Physician Early this year a complaint was received by the Bronx County Medical Society against a certain self-insured employer who persistently failed to give authorization for certain procedures which under the Workmen's Compensation Law require such authorization This matter was brought to the attention of the Chairman of the Workmen's Compensation Board who was requested to look into the matter since it involved a violation of both the letter and spirit of the Workmen's Compensation Law The matter received the attention of the Chairman of the Workmen's Compensation Board who failed, after the investigation pursued by her, to notify the Medical Society as to the result of the investigation She contended that a report of the investigation "would not be appropriate" She stated, however, that she welcomed the assistance of all responsible parties in advising her when improper procedures come to their attention It is the contention of the Medical Society that it was entitled to know the result of the investigation and whether the practice complained about was abated

Chemung County Seminar Your Director has been asked to act as moderator in a seminar on Workmen's Compensation to be held by the Cheming County Medical Society in Elmira on Wednesday, Septem-

ber 17, 1947

## New Business

Appointments -It was voted that the following appointments be confirmed Committee on Geriatrics (Subcommittee of Public Health

and Education)

Stephen R Monteith, Nyack, Chairman Scott Lord Smith, Poughkeepsie C Ward Crampton, New York Wardner D Ayer, Syracuse

Session Officers Chest Diseases

Joseph J Witt, Utica, Chairman Foster Murray, Brooklyn, Secretary History of Medicine

Claude E Heaton, New York, Chairman Fenwick Beekman, New York, Vice-Chairman Richard A. Leonardo, Rochester, Secretary

Physical Medicine

Jerome Weiss, Brooklyn, Chairman George F Bock, Watertown, Secretary Approval of Appointment of Dr John B Healy, of Babylon, and Dr Leo T Flood, of Hemp-stead, to the Regional Hospital Planning Councıl of Suffolk and Nassau Counties

Contract Renewals -It was voted that the Board of Trustees be requested to renew the contracts of Dr Kaliski, Dr Hannon, and Mr Farrell

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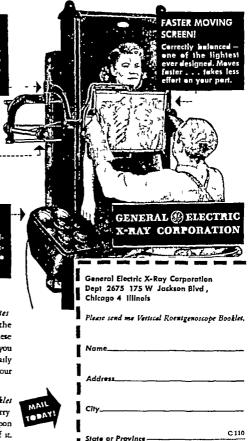
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### Officers—County Medical Societies—1947

#### TOTAL MEMBERSHIP AS OF OCTOBER 15, 1947-21,444

President

County

Secretary

Treasurer

County	President			Бестега		116481	
Albany				ander Veer		F E Vosburgh	Albany
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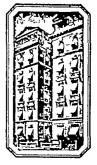
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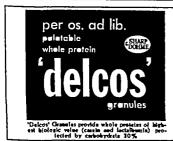
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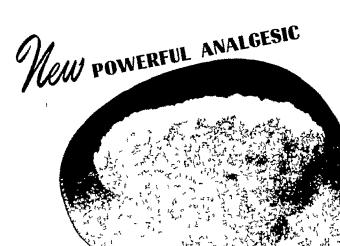
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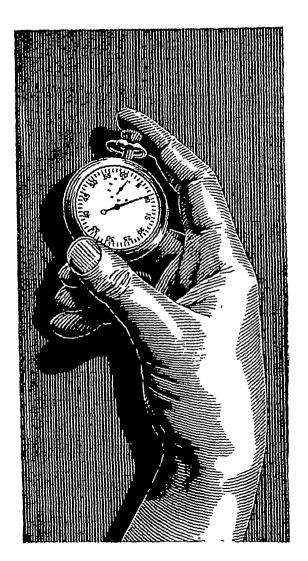
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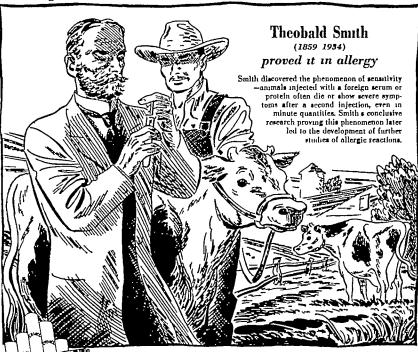
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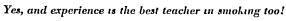
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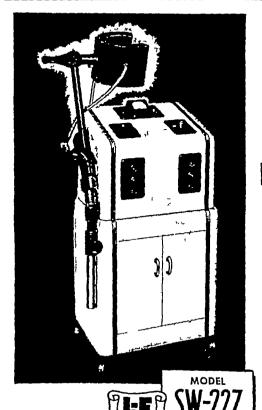
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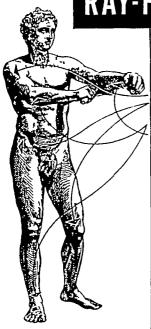
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REMARKS: immediate relief of itching

... no irritation ... no recurrence
... no irritation ... no

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We can't tell you how to reform them, of course But here's a suggestion that will make things easier for you and the parents in those cases for which the administration of sulfadiazine is indicated Prescribe Sulfadiazine Dulcet Tablets The brats will like them So will cherubs And so, for that matter, will many adults who have difficulty in swallowing tablets and capsules, or who should use sulfadiazine tablets as troches for local effect • Sulfadiazine Dulcet Tablets are candies in appearance, in taste, in odor, and in the way they melt in the mouth Yet they are accurately and scientifically standardized to produce the desired therapeutic result. Sulfa diazine Dulcet Tablets are stocked by prescription pharmacies in two sizes 016 Gm (2½ grs), and 032 Gm (5 grs) They may be chewed, dissolved on the tongue, or taken in a little water Prescribe the same dosages as you would with conventional sulfadiazine tablets Would you like a physician's sample? Just drop a line to Abbott Laboratories, North Chicago, Illinois

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\*Goldthwait, J E, Brown, L Y, Swaim, L T., and Kuhns, J. G., Body Mechanics in Health and Disease, 103-105, J B Lippincott Co, Philadelphia, 1937

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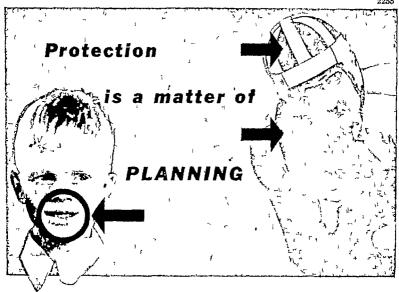
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FOR ABDOMEN BACK AND BREASTS

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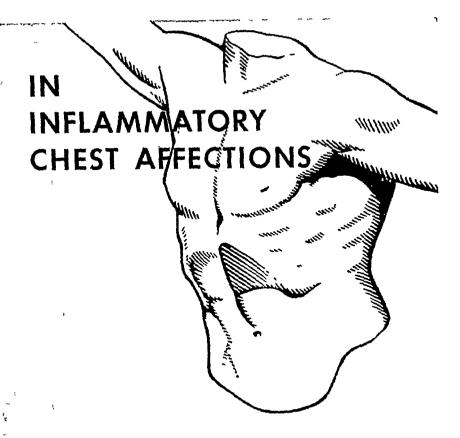
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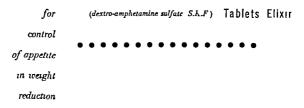
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Does the rather prolonged administration of Devedring cause any evidence of disturbance of tissue functions?

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# And Protein Deficiency

While protein deficiencies per se are difficult to recognize in their incipiency, conditions which lead to negative nitrogen balance are well known. The presence of any of the following states which characteristically exert an adverse influence on nitrogen balance, calls for immediate measures to prevent serious protein depletion.

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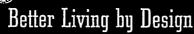
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Physicians'

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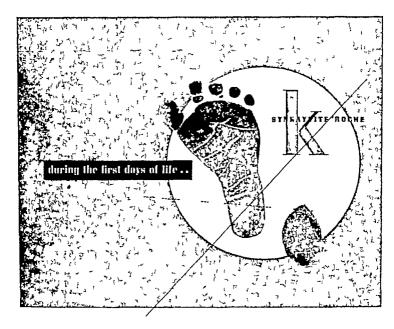
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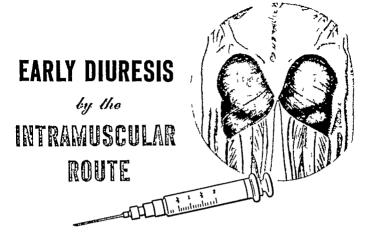
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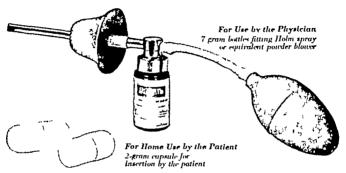
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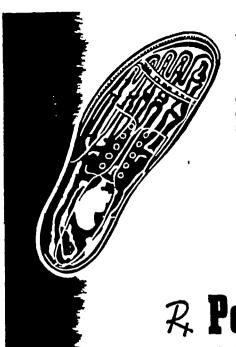
fluffiness which makes for easy insufflation and with an attraction for water which promotes fast action

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> \*Reich, B then and Nechtose "Treatment of Trichomonas I agi alls Vaginitis, Surgery Cynecology and Obstetries M y 1947 pp 891-896



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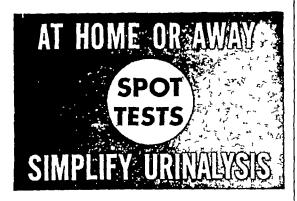
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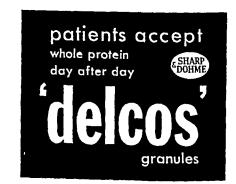
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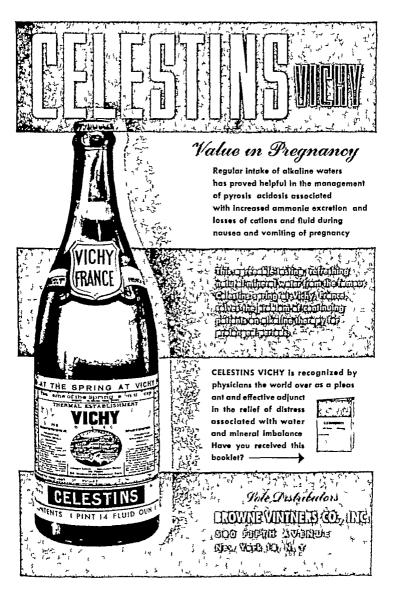
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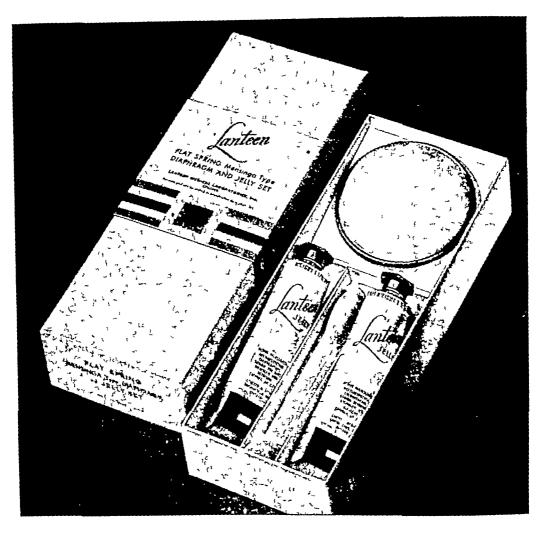
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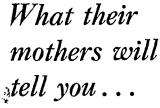
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VOLUME 47

NOVEMBER 1 1947

NUMBER 2.

#### **Editorials**

BCG

In the State of New York, the campaign to oradicate tuberculosus goes forward — The State Department of Health has commenced its production of BCG by the Division of Laboratories, and, as stated in these columns carlier in the year, a well-integrated program has been the subject of much careful planning for the use of BCG for the active immunization of tuberculin negative reactors against tuberculosus in NewYork State

The Council Committee on Public Health and Education of the Society and representatives of the State Department of Health have worked out many essential details of the organization of procedure, a difficult task for a populous state as large as New York.

Interest in BCG will necessarily become more widespread as the public is informed of its use in the campaign against tuberculous. Anticipating for the physicians of the State some inquiry by patients, we present a brief review of the development of this preparation of viable organisms

It may not be recalled that Guérin, collaborator of Dr Calmette, director of the Pasteur Institute in the research and development of BCG, was a veterinarian. BCG

1 New York State J Med. 47: 698 (April 1) 1947

1 "Veterinary Contributions to BCG Vascination" by
Alberto Assoil Vat. Med. 42: 254 (May) 1947

stands, in fact, for Bacillus Calmid Guérin, a strain of Mycobacterium telescope of the bovine type attenuated by the sage through experimental media. Was had begun in 1915 to establish the faction noss to man of the 70th transfer at 150 Belgium, when it was interrupted to German Army which requisitioned was german Army which requisitioned was a superfect to the control of the c

After the war, resuming the mette and Guérin demonstrain strain Nocard (who was anothers as a strain Nocard (who was anothers as a strain notary the strain after passage the ments on bile media and "was no longer the attenuated all refractory to the movirulent tubercle. This was reported in the Annalles de From 1924 to

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by an Austrian immunologist that BCG produced characteristic lesions in laboratory animals in Austria. The Veterinary College in Milan, together with the medical schools in Milan and Pavia, collaborated in supervising the experimental work on farm cattle donated by the farmers and kept in isolated stables. It was found that "BCG vaccination protected the calves not only against artificial inoculation with cultures of virulent tuberculosis organisms, but also against natural exposure consisting of constant contact with tuberculous cattle"

At a meeting of experts at the Pasteur Institute in 1929 at the invitation of the League of Nations, the work done in the Povalley in Lombardy was favorably received as was that of Guérin, Dr Watson of Canada, however, receiving them "with reservations" Later, in Oslo, the unfortunate "incident of Lubeck was redeemed by Neufeld" and the "continuation of the use of BCG in human beings" was decided affirmatively

Results of the Italian experimentation on cattle which lasted thirteen years "coincide strikingly" with the results on the American Indians which were presented at the conferences held in September, 1946, at the Tuberculosis Control Division of the US Public Health Service in Washington <sup>3</sup>

In this country, large-scale programs for the use of BCG are being developed in the war against human tuberculosis, not only in New York State, but elsewhere The State of Illinois has authorized construction of a \$361,000 institution for tuberculosis prevention on the Chicago campus of the University, which contemplates the large-scale production of BCG

The European veterinary contributions to the development of this vaccine have been In this country, the tuberculosis eradication program which has been operating for twenty-five years has gone very far in climinating the disease in cattle Tuberculm testing as practiced here has not revealed in any state "as many as one-half of one per cent positive reactors to the tuberculin test on the last complete survey " The quotation is from a letter from Dr William A Hagan, Dean, New York State Veterinary College, Cornell University, Ithaca, Dr Hagan says further New York feel, however, that we will have to continue the program that has been so successfully operated, and which has made of this disease a very minor problem in the country"

From this it will be seen that no vaccination program for cattle in this country has been necessary, and that it would only complicate the tuberculin test which has served so well to reduce the disease here to "a very minor problem" in cattle

Carefully controlled use of BCG for the reduction of tuberculosis in human beings may well serve to reduce still further the incidence of the disease in cattle since, as Dr Hagan reports "In at least two instances that I know of in New York (State), it was shown fairly conclusively that the owner was harboring bovine bacilli in open pulmonary lesions and it was from the owner that the cattle became infected"

#### The Hysteric in General Practice

We have just read and reread an article under the above title appearing in a British medical journal <sup>1</sup>

The British character has qualities that we conspicuously lack. It is not excitable. It is not talkative. It thinks. It is rather self-deprecatory than otherwise, but when it troubles to unburden itself it often comes up with something very well worth listening to

Dr Lester's article is based on the study of a single case. She is a married woman crowding fifty, the mother of a single daughter. He has studied her from the Freudian, Adlerian, and Jungian points of view. He has gone with equal care and detail into the personal histories of her husband and her daughter. He gleaned invaluable facts of her childhood from an aunt who lived nearby, and, we gather, never could abide the child

<sup>\*</sup>Tuberculosis Control Issue No 4 Public Health Reports 61 23 (1946)

<sup>4</sup> Herald Tribune (July 20) 1947

<sup>1</sup> Lester Wilfred The Practitioner 158 425 (May) 1947

She is an outwardly well-nourished, cheerful, placed woman who, to the casual observer, would seem to be bearing up extraordinarily well under the mexplicable multiplicity of ills to which for years she has been a prey She never knows when her heart, her back, or her internal organs are going to give way under her But they are always doing so, oddly enough on occasions when she is not the center of the picture peoples' weddings, other peoples' birthday parties, her husband's lodge nights, her daughter's rare evenings out with her young man, frequently seem to precipitate an attack which requires that everyone's un divided attention be centered on Mother

To be sure, she always recovers, but it is always a jolly near thing. And the oddest part of it is, my dear, that those doctors can never find anything the matter with her. In fact, doctor after doctor has told her, in no uncertain terms, that she was nothing but a hypochondriac. She didn't know what that meant, but she made very certain that users of the term never again crossed her threshold. In fact, her battles with the stupid, incompetent, unsympathetic members of the medical profession are the staple of her conversation.

Dr Lester has written such a masterpiece that in attempting to condense it we feel like someone, not Walter Pater, trying to describe the Mona Lisa At that, "our eyelids are a little weary"—already—as are those of everyone who has come in contact with this fearful woman

She was the seventh and unwanted child of an irritable, worn out mother and a kindly, reckless, drunken father She nursed at the breast for two years and then became an un breakable thumb sucker A man exposed himself before her at the age of six. On the death of her father, when she was four, her mother had to go out to work and she had to go to school There she did fairly well, except when she suffered inexplicable attacks of vomiting which prevented her from ever taking examinations. She got along well with other children except that—this detail was supplied by the acid aunt—they must

always be younger than she. She was ardently woodd by a very masculine sailor, but rejected him because of his very ardor After four years' courtship she married a sorter of mail in the post office whose avocation was the raising of rabbits in the backyard had been previously an officer in the Boys' Brigade He took great pleasure in his uni After two years of tentative, shy, form fumbling, mutually unsatisfactory attempts at consummation of matrimony, she presented her husband with a daughter, but the experience was so unbearably horrible that their matrimonial relations dwindled to what might be called token performances, occur ring perhaps twice a year, on birthdays

Dr Lester, after years of patient effort, finally succeeded in so enlightening the various members of the family that their attention to "the attacks' lessened Her husband and her daughter were still kind and solicitous and affectionate, but the husband managed, in spite of them, to get to his lodge meetings and the daughter to go out with her young man And under such a policy of judicious neglect the mother herself eventually improved How the doctor managed to bring this about without getting himself fired from the case is a riddle to which only Dr Lester holds the key But the reporting of one such case as this is worth pages upon pages of statistics.

We think the article of great importance for two reasons. First, because there is no doctor—and we use the term advisedly—whether the doctor be general practitioner or specialist who will not immediately recognise many of the characteristics of Dr Lester's Mona Lisa in his own practice.

Second, because it shows what a mere doctor without special psychiatric training can do by sympathy and understanding to been one of the greatest heartaches that afflict people in general. He could not dor' if he were a full time professor, even if be had the vague wish to try to do so, becare his life would not have furnished hum the recessif

If he were practicing und Society

#### Current Editorial Comment

Charity—It Needs a Follow-up System Thirty years ago a surgeon who removed a patient's appendix and was so fortunate as to have the patient leave the hospital under his own steam, so to speak, was adjudged to have done a good job, and the hospital proudly wrote down that patient on its record as "cured" There were optimists in those days Nowadays patients are fol-Relentless social workers camp upon their trails They point out that even minus an appendix a patient, unhappy at home, will go on to develop gastric or duodenal ulcers, mucous colitis—gracious Heavens, won't they get? Is there, nowadays, a surgeon who is fatuous enough to think that the unassisted knife can cure anything? Not if he's heard of psychosomatic medicine Follow-ups may be discouraging, but we believe in them in principle So we print the gist of a letter, received from a correspondent the other day

I live on what I am sure you would call a civilized block in New York City. It is in a neighborhood which has become fashionable in the last twenty years. Certain properties on my block have remained unchanged. One of them is a brownstone house of conventional design, whose stoop sticks out like an unblown nose in the middle of a row of stoopless, remodeled, repainted houses. The done-over houses are inhabited by sculptors, playwrights, authors, doctors, and business men, people of fairly moderate means, but, perhaps, above-the-average in intelligence.

The brownstone front has a blue enameled sign in front of it which says Hospital Street Quiet Please Otherwise there is no designation on it to mark it as a hospital For years I passed it numbers of times every day, without a thought except as to its outward ugliness. Then I found out what it was A home for unmarried mothers. I have never seen the blinds up on the front of the house. Neighbors who live at its sides and in its rear assure me that the blinds are never up there, either. In its sepulchral interior its unfortunate inmates sing hymns.

The chatelaine of this establishment is a woman of doubtful age who, among others, has a hatred for dogs. Most of the dog owners on the block keep their dogs on the leash and in the middle of the street. She insults the feminine dog walkers, intimating that instead of having dogs they should have babies. She throws lysol upon her next door neighbors, innocently sitting of an evening in their own back yard. She spies upon a

lady connected with the theatrical business who had the temerity to bring home some men to her apartment after an evening rehearsal to discuss changes in the play, shouting insults at her from her window

When complaints were made, the "charitable organization" that is so tenderly solicitous for the welfare of unmarried mothers, replied apologetically that it knew she was not the ideal woman for her position, "but that there was Something in the Terms of the Will that made the Trustees responsible for her upkeep until she died" By lumping her with the unmarried mothers they were Saving Money for the Benefit of Posterity

Charles Dickens died in 1870 If he had written this chapter of New York life before he died we would have had difficulty in believing it But it's true

We believe our correspondent, because we have investigated the circumstances ourselves. It supports our argument that charities, as well as surgical services, are in need of Follow-Up Services.

The Doctor-Descending Scale Some weeks ago we encountered an old friend at a funeral He said he must be getting old That is a conclusion frequently reached by attendants at classmates' funerals, but, curious, we asked him why He said because the whirling particles on the kaleidoscope of his mind were beginning to settle down and take shape Indeed, some of them formed definitely remembered pictures

"Such as what?" we asked

"I'll lot some down for you," he said Some days later he sent the following

When I was in college a classmate asked me to dinner at his home in Boston In flattered timidity I accepted His father, then, was to surgery in Boston what Osler was to medicine in Baltimore

We went into the library It was a typical Beacon Street rear room library If you want to know what it looked like I refer you to The Late George Apley It was the library of a man in very comfortable circumstances A pleasant open fire warmed it Before the fire, upon an old-fashioned reclining chair with an adjustable back, reposed a man A big man, not fat, but solid He had plentiful white hair and a sweeping snow-white cavalry moustache His cheeks and his big nose were red, but of an outdoor redness, not the dull

purple of small ruptured veins His right foot was well elevated on a stool and at his right hand, on a small table, stood a half empty bottle of Burgundy and a glass As his son introduced us he waved a genial hand, indicating his foot

"Gout, you know Can't get up Eight operations today Tired." He pointed to the bottle "Shouldn't drink it, but, after all, muzzle not the ox that treadeth out the corn A man

must have some joy in life."

He was one of the most respected citizens of Boston. To have him take our your appendix was the equivalent of knighthood. As I recall, he had a very pleasant life, died no sconer than he should have, in spite of his well known fondness for his bottle, and was mourned by grateful friends and patients from every walk of life. I never heard of anyone envying him his carriage his horses, or his house on Beacon Street. On the contrary Boston was proud that it had been able to support such a man in the comfort the community felt he merited.

Fifteen years or so later, I found myself again in Boston I was at a medical dinner and the subject of full-time professors was under discussion. Someone remarked that fifteen thousand dollars a year was ample for their maximum salary.

"Not in New York City," I observed

The comment was received with lifted eyebrows all around the table I was annoyed

"A professor has a certain state to keep up" I said "He is supposed to entertain vixining firemen His household and his table should seem worthy of a professor He is supposed to give his children the same educational advantages he himself enjoyed He and his wife are supposed to dress according to a certain standard, so that they may reflect credit on their University They are supposed to go abroad, so that the professor may join International Societies and so that his name may be known far and wide upon the face of the carth Try and do that in New York on fifteen thousand a year'

A professor of the type mentioned addressed me in a tone of strained tolerance tinged with contempt for my avarice

"Ah, but Doctor," he said, send your children to the public schools."

"Did you?"

He turned quite red "No," he answered

"Why not?

"My wife wouldn t let me." His wife, I discovered later, was a very charming fastidious and wealthy lady No doubt he had forgotten that My last experience with a Full Time Man was under the roof of one of our best known Medical Schools. He was evidently proud to be in charge of a hospital service of two thousand mice. One thousand were of a strain predisposed to cancer The other thousand were not. The doctor supereted that cancer might be induced by feeding the noncancerous mice on the milk produced by the cancerous strain. In order to do this he had to learn to milk a mouse He had done so, I saw him do it

We are grateful to our friend for these three vignettes To some they may seem totally unrelated scraps of reminiscence. They don't seem so to us They illustrate very well the disturbing chronicle of what is happening to the doctor during the span of less than one man's lifetime.

The first picture is that of the doctor as one of the most respected men in his community. The better living he made the prouder his neighbors were of him because he made them proud that they were able, properly, to support a man to whom the entire community, neh and poor, were grateful

In the second the doctor depends on someone else for his livelihood. There is nothing For centuries mens unusual about that love has been tempered by considerations of money But, then, he, from the stronghold of his uxorious independence, presumes to impose upon others less fortunately circumstanced his ideas about what he thinks a full-time professor should earn Those who accept his terms are submitting to the judgment of others the amount of the reward they think is fitting the world should grant A most important and significant step downward from the path of rugged individualism A doctor expects a layman when he is sick, to do what the doctor orders Why, then, when the layman is well, should the doctor submit to the dictation of men who in their time of trouble turn to him as a man of superior wisdom? It is entirely a matter of money The power of the purse We admonish the members of our profession to be careful and realous of the independence they relinquish for the new hospital building or for the glitter of the title of professor As for picture number three. Conceded

that from the labors of such men there may eventually come a cure for cancer We applaud them for unselfish zeal But why waste four years of the coveted privilege of medical education on the type of man who wants to—or has to—spend his life riding herd on muce? Int't that using buckshot to

shoot snipe? We can't help thinking of the monks who packed the monasteries of the Middle Ages, and for three meals a day would do anything from cleaning the cowstables to illuminating manuscripts for the Greater Glory of God Only today we call it for the greater glory of Research

Nurse Shortage Continues To those who had hoped for alleviation of the wartime shortage of nurses by now we can bring only bad news Says the New York Times 1

Although there are more professional nurses in the United States today than ever before, the wartime shortage of nurses still exists, and is in many ways even more acute than at the The number of registered height of hostilities nurses in the United States has increased from 295,000 in 1931 to 317,800 in 1946, but the number of patients entering hospitals increased during that same time from 7,058,000 to 15,159,-000-a 13 per cent increase in the number of nurses, but more than a 100 per cent increase in the patient load Last spring the American Hospital Association reported that 16 per cent of the hospitals in the United States had a total of over 33,000 beds closed because of lack of nursing personnel

Nor does the situation appear to be easing, for only 30,899 student nurses were admitted to training in 1946 compared with 56,567 in 1945. Failure to attract suitable candidates to the field of nursing in sufficient numbers has been attributed to a number of factors—competition of other occupations, no more wartime patriotic appeals, and the end of funds provided by the Bolton Act, supplying individual subsidy for cadet nurses

Reduction of working hours from 48 to 40 in New York City hospitals, in effect now for a year, together with minimum salaries increased by \$600, seems to have failed to attract more nurses. In city hospitals of New York, according to the Commissioner

of Hospitals, about 2,400 positions remain unfilled

What is the solution? The Times suggests that

The ultimate solution of this problem can only be met by a long-range educational program that will provide more students of nursing However, it is felt by many leaders in both the nursing and medical professions that nursing education must be reorganized so as to provide nurses in three categories highly trained teacher, research worker, and top administrator in all fields of nursing, (2). the trained graduate nurse, who would operate primarily in a supervisory capacity and in the highly technical field of nursing requiring special professional judgment and skill, and (3) the practical nurse, who could be trained in a much shorter period of time and who would perform the average duties of bedside nursing under adequate supervision

This is a long-range program However, the present emergency can only be met by some immediate action

We submit that, granting the validity of the program suggested by the *Times*, it would be well also to inquire into the reasons why young women no longer, apparently, are minded to enter nursing as a profession. Have we opened so many more attractive careers to women that the older standbys of teaching and nursing have lost their allure?

Surely the teachers as a profession have taken a beating by reason of public indifference to their appeals for a decent wage. No one will deny that student nurses and others in the past have been exploited by the institutions for which they worked and by unreasonable demands on the part of individual patients. Are we now reaping the rewards of such past folly in the indifference of young people toward nursing as a career?

For a Special Announcement about the

Scientific Exhibits for the 1948 Annual Meeting, please see page 2310

<sup>&</sup>lt;sup>1</sup> September 13, 1947

#### Scientific Articles

#### THE EFFECT OF ANESTHESIA AND SURGERY UPON PATIENTS WITH PULMONARY TUBERCULOSIS

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THIS is a preliminary report of the extra thoracic procedures. A similar review of effects following major chest surgery is to be reported at a later date.

The patient with pulmonary tuberculosis who requires surgory has always presented a problem to the anesthetist. Frequent publications in the past have discussed the problem of the choice of anesthesia with a view to minimising the extension of the pulmonary discase. 12 The alterations in physiologic response to various anesthetic agents and technics were discussed and certain concepts formulated. 2-7

In this paper, a series of anesthetic administrations on patients with pulmonary tuber culosis is reviewed with regard to the spread of disease in the postoperntive period, and the results are presented. All types of anesthetic technics and agents, except local infiltration and topical application, have been utilized. The series includes emergency and elective ther apeutic and diagnostic surgical procedures. The analysis of the course of the disease in the postoperntive period is presented in relation to (a) status of the pulmonary disease at the time of operation and (b) technic and agents employed for anesthesia.

The analysis of the status of the pulmonary tuberculosis at the time of operation will be presented first. The cases are divided into two major groups those with active pulmonary tuberculosis and those with arrested disease. For purposes of evaluation of the individual case we have classified each by its clinical and roentgenologic appearance at the time of operation. Minimal disease includes slight leasuns without demonstrable excavation confined to a small part of one or both lungs but the total extent of lessons regardless of distribution does not exceed the equivalent volume of lung tissue which lies above the second chondrosternal

junction Moderately advanced disease in cludes slight, disseminated lesions which may extend through not more than the volume of one lung or its equivalent in both lung fields, or dense and confluent lesions extending through not more than the equivalent of one-third the volume of one lung. Cavitation, when present, does not exceed 4 cm in diameter. Far advanced lesions include any excess of these conditions.

Clinical evaluation of arrested disease is that in which constitutional symptoms are absent. Sputum must be negative on concentration for tubercle bacilli. Lesions must be stationary without evidence of cavitation by x ray conditions must have existed for a period of six months the last two of which the patient has been taking one hour of walking exercise twice Quiescent disease is that in which there are no constitutional symptoms Sputum may contain tubercle bacilli Lesions are stationary by x ray and a cavity may be present. These conditions must have existed for at least two months during which time the patient has been ambulant. Active disease is that in which x ray discloses incompletely healed lesions, positive sputum, and symptoms present in various degrees

These requirements are essentially those of the National Tuberculosis Association and, except those cases classified as 'quiescent' are included by us as 'active'.

Of the 282 anesthetic administrations, 208 were to patients in various stages of active pul monary tuberculosis, and 74 were to those with arrested disease. It has been observed in this entire sense that the incidence of extension of the disease as determined by radiographic means was 10 9 per cent in the one-month period fol loving surgery. No patient with arrested disease showed evidence of spread

The distribution of patients in accordance to the stage of pulmonary tuberculosis at the time of operation reveals that the largest number

Presented at the 141st Annual Meeting of the Medical Roclety of the State of N w York Buffalo M y 7 1917 Section on Artsthesiology 6 Dr Lottum and Dr Parke poke by invitation.

were far advanced and, following in order, moderately advanced, minimal, and primary Eight cases are grouped separately, as the exact stage of pulmonary tuberculosis was not determined (Table 1)

TABLE 1 —DISTRIBUTION OF CASES BY STAGE OF PULMON-ARY TUBERCULOSIS

	Far- Ad- vanced	Mod- erately Ad- vanced			Not Deter- mined	Total
Cases with ac tive pul- monary tu berculosis Cases with ar- rested pul-	141	50	12	2	3	208
monary tu berculosis	24	17	24	4	5	74
Total cases	165	67	36	6	8	282

The incidence of spread in this distribution shows that the highest percentage (132) per cent occurs in those groups classified as minimal, (138 per cent), and far advanced, (133 per cent)

In the latter, this figure (133 per cent) is based on 22 extensions (18 patients) in 165 procedures. However, in the former group of 36 procedures, the 5 which showed extension of the pulmonary tuberculosis occurred in 2 patients, giving an incidence of 138 per cent

The group classified as moderately advanced consisted of 68 procedures and had 4 spreads on 4 individual patients, representing 5 9 per cent

TABLE 2—Incidence of Postoperative Extension of Pulmonary Tuberculosis by Stage of Disease

	Perce Far Ad- vanced	ntage Mod- erately Ad- vanced	Mini- mal Per cent- age	Prim-	Not Deter- mined
Incidence of spreads in ac tive cases Incidence of	15 6	8	41 6	0	0
spreads in ar- rested cases Incidence of	0	0	0	0	0
spreads in en tire series	13 3	5 9	13 8	0	0

The presence or absence of tubercle bacilli in the sputum was thought to be a possible factor inciting extension of the pulmonary disease. The arrested cases, by definition, have negative sputum. Therefore, we shall examine only the active cases in considering this factor. It was found that 108 patients had positive sputum at time of operation and of this group 22, or 204 per cent, showed spread in the immediate post-operative period. Of the 100 cases with negative sputum, 9, or 9 per cent, showed evidence of extension in the same period.

TABLE 3 -BACTERIOLOGIC FINDINGS

	Total Cases	No Spread	Spread	Percent- age of Spread
Incidence of positive sputum in active cases	108	86	22	20 4
Incidence of negative sputum in active cases	100	91	9	9

Thirty patients in the entire series manifested laryngeal tuberculosis and in 10 of these the pulmonary lesions spread. Every one of the 10 had positive sputum on concentrate at the time of operation

TABLE 4 —Incidence of Extension in Relation to Collapse Therapy

With collapse therapy Without collapse therapy	Total Casea 81 125	No Spread 72 105	Spread 9 22	Percent age of Spread 11 2 17 6

Collapse therapy of various forms which included pneumothorax, both intra- and extrapleural, thoracoplasty, and phrenic crush totaled 81 cases in the active group. Of these, 112 per cent, or 9 cases, evidenced extension of the pulmonary disease. Eight of these 9 cases also had positive sputum. The remaining cases in the active group without collapse therapy number 125. Twenty-two, or 176 per cent, of this number spread.

The most common type of pathologic lesion seen in this series of cases with active pulmonary tuberculosis is the combined evidative-productive type. There are 154 cases in this category, of which 19, or 123 per cent, showed evidence of extension following the surgical procedure. Patients with an exudative type alone numbered 29, 6, or 207 per cent of these spread. The productive type disease was found in 20 cases, and of these 6, or 30 per cent, had extension. These observations, except for the incidence found in cases with the productive type of disease, would appear to be as expected.

This series of cases is about equally distributed between men and women, not only in the total but when divided into groups of arrested or active pulmonary tuberculosis. Also, the incidence of spread is as evenly divided between the seves

When the racial distribution is reviewed, it is found that most of the patients are white, with an incidence of 97 per cent spread. The negro patients made up 18 per cent of the total number and had a higher incidence of spread, 16 6 per cent, than the white group. Only 5 Chinese patients were operated on in this series. One of these spread in the postoperative period.

#### Types of Anesthesia

Spinal Anesthesia -One hundred and six

spinals were given, and of these 12, or 11 3 per cent, showed spread. It had been necessary to supplement the spinal in 6 instances, 4 with cyclopropane and 2 with sodium-pentothal. One

of the later group spread

Reynord Block Anesthesia.—Sacrocaudal, bra
chial, abdominal, intercestal, and field blocks
are included in this group of 52 cases. Three,
or 57 per cent, exhibited spread in the postoperative period Each of these spreads followed
a surgical procedure for which a transsacral cau
dal block had been given. Eight of the regional blocks were supplemented with general an
esthesia, 5 with cyclopropane and 3 with pentothal-sodium. None of this group showed
spread of the pulmonary tuberculesis in the
postoperative period

Intravenous Anesthesia.—Intravenous anesthesia using pentothal-sodium in a 25 per cent solution was employed 51 times as the primary anesthetic for short operative procedures. In instances, or 9.8 per cent, there was spread of the pulmonary subgreates within one month

Inhalation Anesthena - Inhalation anesthesia was used as the primary technic 73 times with 11, or 15 per cent, spreads. Cyclopropaue was the agent administered in 59 of these cases. 9 or 152 per cent, of these spread Ether was used only 8 times and showed an incidence of 2 extensions, or 25 per cent, of the pulmonary di sease. In one of these cases, ether was used fol lowing a cyclopropane induction and in the other it was used with avertin. Both procedures were bronchoscopic examinations and both were performed on the same patient within a month and a half The other agents used were Vincthere which was employed in only 4 instances and nitrous oxide in 2 There were no spreads with agents

In the series of 232 extrathoracic procedures, endotracheal tubes were used on 24 occasions Following 4 of these procedures, an incidence of 16 6 per cent, there was extension of the pulmonary disease. Laryngotracheal at the time of operation in 30 cases Endotracheal intubation was performed on 4 of these cases, only 1 of which spread post-operatively

Surgical procedures on the upper abdomen on patients with pulmonary tuberculosis have generally been considered to increase the possibility of spread of the pulmonary disease. In this series, 60 major operations were performed upon the abdomen using various anesthetic agents and technics. Forty-eight were upon the lower abdomen or kidney, 13 upon the upper abdomen. There was a total of 7 spreads, 6 following the procedures on the lower abdomen and 1 following a jejunostomy

For distribution according to surgical procedure for all cases, see table 8

TABLE 5TYPE OF AMBSTHEMA TECHNIC						
	Total	Spread	Percentage of Spread			
Inhalation	73	11	15			
Intravanous	51	- 8	9.8			
Spinal	106	12	11 3			
Supplemented	(6) 52	(1)				
Regional	52	`a	5 7			
Supplemented	(7)					
• •	خند					
Total	282	31	10 9			

TABLE 6.—Inhalation Agents Used					
	Total Cases	Spread	Percentage of Spread		
Cyclopropene Ether Vinethene NyO Endotracheal tube	59 8 4 9 24	2 0 0 4	15 2 26 0 0 16 6		

	Arrested Cases Minutes	Active No Spread Min	Spread
Longest procedures	346	180	120
Shortest procedures	10	7	5
Average	93	58	58

			No Ac	tive
		Arrested		Spread
1	Head and Neck		•	•
	Thyroidectomies, hemigios-			_
	sectomies etc.	1	4	3
2	Minor Chest Cases a Incision and drainage			
	chest wall abscesses	4	19	•
	a Repacking chest wall	-		
	cs vities	1	28	4
	c E o breast or chest wall	_	_	
	d Incision and drainage	3	4	
	d Incision and drainage mediantinal abscesses		1	
	Upper Abdominal Cases		•	
	a Gastroenterostomies			
	gastrio resections, gas-			
	trostomies, jajunos-	_		
	tomy  h Entercentercetomies, in	2	10	1
	<ul> <li>Entercentercetomies, in testinal resections</li> </ul>			
	Lower Abdominal Cases			
	s Exploratory laparot			
	omy appendento-			
	mies hysterectomies,			
	hysterotomies. Colos-			
	tomies closure colos- tomies sophorecto-			
	mies, suprapubic cys-			
	tostomies, outaneous			
	ureterostomies	10	21	6
	h Nephrectomies	3 2	3	
	c Hernia repairs d. Combined abdominal	2		
	perineal resections	1		
	Perineal Rectal Genitouris			
	ary Cases			
	<ul> <li>Dilatations and Curst</li> </ul>			
	tages cystocele and rectocele repairs	8		
	b Rectal operations	š	34	
	o Cystoscopies and retro-	•		
	grade pyelograme	20	17	2
	d Epididymeetomies, or			
	hidectomies, incision and drainage—scrotal			
	abscess	2	٥	3
	Orthopedi Cases			
	a Inciden and drainage			
	Pott absesse spinal	2	8	2
	fusions t Orthopedic operations	•	٥	•
	extremities	7	7	1
	Embolectomy kin graft exc. bemangi			
	graft exc. bemangi	1	2	

When the individual patients who showed extension of the tuberculous pulmonary lesions in the postoperative period are reviewed individually, it may be seen that certain of these patients show very definite time relationship between the surgical procedure and the chest In other cases, however, the replate findings lationship is questionable—In these latter, certain ones were already following a progressively downhill course when surgery and anesthesia were in-In others, it may be seen that several anesthetic administrations were given to a single patient within a short period of time and it is impossible to determine which procedure, if any, might have been the cause of the spread patients had, in addition to their pulmonary tuberculosis, other serious pathologic conditions which caused the demise of the patient before definite evidence of a questionable spread could All patients who showed exbe established tension of their pulmonary lesions in the postoperative period, whether the spread was definitely related to the operative procedure or suspected of being so, have been included

Following is a brief resume of the clinical status of each patient that spread, including (a) status at the time of operation, (b) operative procedure, (c) anesthetic agent and technic, (d) duration of anesthesia, and (e) postoperative course

#### Far Advanced Pulmonary Tuberculosis

Case 1—M A, a white woman, aged 45, with exudative-productive cavitary disease, highly positive sputum, complicated by laryngeal broncheal tuberculosis, showed progressive extension for at least six months following a second-stage thyroidectomy Cyclopropane inhalation anesthesia through an endotracheal tube was administered for one hour, using to-and-fro carbon dioxide absorption technic

Case 2—E B, a negro man, aged 30, with severe symptoms, positive sputum, exudative-productive disease, and laryngeal complications, showed progressive spread and died (of a hematogenous dissemination) three and one-half months following incision and drainage of the right elbow. Cyclopropane inhalation anesthesia was administered for forty minutes.

Case 8—C E, a negro man, aged 26, with positive sputum and evudative-productive disease, showed spread to the opposite lung within one month post-operatively and then no further change for at least six months. The operative procedure was incision and drainage of a perirectal abscess under 2½ per cent pentothal-sodium (400 mg) and took fifteen minutes.

Case 4—J F, a negro man, aged 35, with severe symptoms, positive sputum, evidative-pneumonic type disease, with effective pneumothorax, spread progressively and died four months later following an incision and drainage of a perirectal abscess. This

procedure was performed under a transacral caudal block and took thirty minutes

Case 5—H G, a negro woman, aged 35, with positive sputum, evudative-productive disease, who had a thoracoplasty done six years previously, died twenty-one days after a hysterotomy and sterilization. The postmortem findings showed a recent bronchogenic spread. Spinal anesthesia was given for the procedure using pontocume-procaine mixture and the level was established at T-7. The procedure lasted one hour, with hypotension being the only complicating factor.

Case 6 —F G, a white man, aged 41, with positive sputum, pneumonic exudative-productive disease, complicated by carcinoma of the pancreas, was following a progressively downhill course at time of operation. He died of carcinomatosis and peritonitis six days postoperatively. A jejunostomy was performed under cyclopropane inhalation anesthesia using an endotracheal tube and to-and-fro carbon dioxide absorption technic. Duration was one and one-quarter hours. There were no complications during the administration.

Case 7—R H, a white woman, aged 26, with moderately severe symptoms, positive sputum, condative-productive disease, complicated by bronchial involvement, showed evidence of spread in the first month postoperatively and no further change for at least six months thereafter. The operation consisted of a fistulectomy performed under precaine spinal anesthesia (level T-6) in a fifty-minute period.

Case 8—B L, a white woman, aged 19, with negative sputum and pneumothorax, manifesting evidative-productive disease, showed a questionable extension of the pulmonary lesions in the first month postoperatively which became definite at three months. The procedure was a retrograde pyelogram done under pontocaine-procaine spinal anesthesia. The level of anesthesia established was T-4 Duration of the procedure not recorded.

Case 9—A J, a negro man, aged 28, with far advanced tuberculosis and large right upper lobe cavitation, had had a first-stage thoracoplasty two months prior to this procedure. His disease was apparently not stable. He had shown evidence of prior bronchiogenic disseminations which again appeared at the time of this procedure, which was an incision and drainage of a chest wall abscess under intravenous pentothal-sodium, 450 mg of a 2½ per cent solution. The duration was fifteen minutes and there were no complicating factors.

Case 10—M M, a 39-year-old white woman, had four procedures in one month's time. She had positive sputum, exudative-productive disease, bronchial tuberculosis, and had had an extrapleural pneumothorax one week before this group of procedures. She showed evidence of extension of her pulmonary disease two weeks after the final procedure, followed a progressively downhill course, and died within a month after that. Each procedure consisted of changing chest wall packs and in each case the anesthetic was cyclopropane inhalation with to-and-fro carbon dioxide absorption technic. The duration

was between thirty and forty five minutes each time.

There were no complications involved in any of the four administrations.

Case 11—W M, a white man aged 40 with hematogenous dissemination, positive sputum availative disease and laryngeal involvement, showed progressive extension of the pulmonary tuberculous postoperatively and died three months later A second-stage Mikulics operation was performed under pontocaine-dextrose spinal anesthesis in one hour and fifteen munutes. Seventy five milligrams of pentothal-sodium in a 21/rper cent solution was administered to relieve restlessness 4

Case 12.—A. M., a white man, aged 32 had a hemorrhondectomy under sacrocaudal anesthesia using 50 ec. of 1 per cent novocaine with 1 40 000 cobefrin. The procedure lasted one hour The pulmonary disease was far advanced at the time of operation and within a wook he developed a bronchoploural fistula, resulting in a mixed pyogenic and tuberculous empyema and death within two wooks following surgery

Case 15—J O a negro man aged 50 with severe symptoms positive sputum exudative pneumonic disease compileated by generalized hematogeneus tuberculosis had an opididymectomy under pontocalne-procedine spinal anesthesia. The procedure took one hour The patient showed x-ray evidence of massive bilateral pneumonic type of tuberculous involvement of all lobes within twelve days following the operation. His course, thereafter was progressively but slowly downhill and he died five months later

Case 14.—D R., a white voman aged 27, with positive sputum exudative-productive disease, and pneumothorax had an excision of a rectal fistula under sacrocaudal anesthesia. The procedure required one hour Within a month there was x-ray ovidence of extension of the pulmonary disease. This was evidently transient in nature for within three months x rays showed some clearing of the lesions

Case 16—C 8 a white man, agod 58 with severo symptoms positive sputum exudative-productive duscase complicated by bronchopleural fistula and empyema, had an incision and drainage of a cold abscess of the chest wall under intravenous pentothal-sodium 2½ per cent The procedure lasted ten minutes and 625 mg of the drug were used X ray showed increase in the pulmonary lesions at one and one-half months postoperatively but there was no further spread in the six month period following thereaster

Case 16 —A. T a white man agod 35 with negative sputum exudative type pulmonary disease complicated by bronchopleuro-cutaneous fistula and Potts disease of the fourth fifth and sixth dorsal vertebrne had two operations for incison and drain age of the Potts abscess within a one-month period. On both occasions, cyclopropane anesthesia was aministered, the second time through an endotraches tube. A large amount of purulent material was apsirated from the trachea during induction and maintenance during each administration. The first anesthesia lasted thirty minutes and the second fifty minutes. Within two weeks of the

procedure there developed x ray evidence of pneumonic extension. There was further spread following the second procedure. The patient expired within three months of the second procedure having followed a progressively downhill course.

Case 17—L. U. a white woman aged 20, with moderate symptoms positive sputum exudative pnoumonic disease, complicated by tuberculou enteritis, had an exploratory laparotomy under pontocaine-procaine spinal anesthesia. The procedure lasted one hour Postoperatively repeat x rays showed continued increase in a diffuse tuberculous infiltration throughout both lungs and the patient expired within two and one-half months.

Case 18—M. W, a negro woman aged 51 with sovere symptoms, positive sputum, productive-type pulmonary disease complicated by carcinoma of the bladder and pyelonophritis had a cystoscopic examination under procaine spinal anosthesia. The level was established at T 10 Duration of the procedure was not noted. The patient had a rapid downhill course and died on the eighteenth postop-

#### Moderately Advanced Pulmonary Tubercu losis

orative dav

Case 19—T C a white man aged 36 with positive sputum, moderate symptoms exudative-productive disease noted as unstable at time of operation complicated by laryngeal and scrotal tuber culcers, had an amputation under procaine spinal aneathesia of the right scrotum and contents. The level was established at T 10 and the procedure lasted one hour and twenty moutes. The first postoperative x-ray taken one month later showed a questionable extension of the pulmonary keions, which was proved by later x-rays to be definite.

Case 20 —P H a white woman aged 25 with moderately severe symptoms, positive sputum, crudative-productive disease, had an appendentomy under procalue spinal anesthesia. The level was not noted. The procedure took one hour Thore was increase in sputum postoperatively and by x ray in the third postoperative week, there was evidence of extension of the pulmonary lesions. This cleared somewhat within another month.

Case \$1 — B. L. a Chinese man, aged 63, with negative sputum, few symptoms, exudative-productive disease complicated by hyportension and squamous cell carelnoma of the tongue had a hemi glossectomy under nitrous oxide and intravonous pentothal-sodium anesthesis. An endotracheal tube was utilized The procedure lasted one and one-half hours and 500 mg of 2½ per cent pentothal used There was some extension of the pulmonary lesions by x ray one month after the operation with months this extension had retrogressed and the cavity collapsed. No further extension was noted in the next three years.

Case 28 — R. P a white man, aged 20 with positive sputum exudative-productive disease, compile cated by hematogonous dissemination had an opididymeetomy under pontocaine-dextrose-ophedrine spinal aperthesis. The level was established at T

12 and the procedure took one and one-half hours An x-ray revealed a spread of the pulmonary lesions within the first month postoperatively but a checkup at three months showed no further change

#### Minimal Pulmonary Tuberculosis

Case 28—M B, a white man, aged 60, with negative sputum, productive type disease, had two stages of a suprapuble prostatectomy done within ten days. Both stages were done under spinal anesthesia, the first with pontocaine-procaine with the level at T-7, the second with metycaine and the level reached T-10. The first procedure took one and one-half hours and the second one hour. The postoperative course was uneventful until one month after operation when the patient developed a fulminating tuberculous pneumonia and expired within two weeks.

Case 24 -E C, a white woman, aged 37. with negative sputum, productive type disease, complicated by marked emphysema and severe asthma, was bronchoscoped twice within six weeks bronchoscopy was performed under ether and avertin and took thirty minutes The second, five weeks later, was done under ether after a cyclopropane induction and lasted one hour An x-ray taken one week after the second procedure showed slight increase in the pulmonary lesions Six weeks after the second bronchoscopy, a third was planned under pentothal-sodium anesthesia However, it was abandoned when the patient coughed severely on induction and developed laryngospasm Three hundred mg of 21/2 per cent pentothal-sodium was used in a five-minute period. Twelve days later an x-ray showed more extension of the previously noted spread Within a month, retrogression of the pulmonary lesions was revealed by x-ray

#### Summary

The preoperative status and the postoperative course of 282 cases with pulmonary tuberculous have been reviewed. No major chest surgery is included in this series.

A brief outline of the classification of pulmonary tuberculosis is included to clarify the terms used. The cases of this series are grouped according to this classification by the findings present at the time of operation. Other factors, namely the presence or absence of positive sputum, the presence or absence of collapse therapy, the pathologic type of disease, the race, and the sex of the patient, also are investigated. The incidence of spread of the pulmonary disease in the immediate postoperative period in relation to these factors is reported.

The cases were grouped according to the type of anesthesia used, and the incidence of spread for each type is noted. Under inhalation anesthesia the type of agent as well as the use of endotracheal intubation are considered. Other factors examined are the duration of anesthesia and the anatomic region of operative site.

Brief summaries of the 24 patients who showed spread of the pulmonary tuberculosis in the immediate postoperative period are included

- 1 In the entire series of 282 cases, there were 31 that showed extension of the pulmonary tuberculosis in the postoperative period as determined by radiographic means. This is an incidence of 10 9 per cent spread.
- 2 No spread occurred in any of the 74 cases with arrested or apparently arrested pulmonary tuberculosis
- 3 The 31 cases that showed extension of pulmonary tuberculosis were found to have received various forms of anesthesia, including spinal, regional, inhalation, and intravenous. No particular technic or agent was apparently predominant in the production of dissemination of the disease
- 4 It would appear that patients who come to operation with positive sputum, regardless of form of anesthesia administered, are more hable to have a postoperative extension than those who come with a negative sputum
- 5 In the group of patients studied, the presence of any form of collapse therapy in existence at the time of operation seemed to afford a certain amount of protection against post-operative spread
- 6 The incidence of spread in negro patients is almost twice that found in the white patients of this series. Also, it has been observed that the spreads found in the negro group were more extensive and of a more malignant character.
- 7 Distribution of cases and the incidence of spread are equally divided between the sexes
- 8 Site and duration of operation in this series apparently bears little relationship to the incidence of extension of the pulmonary disease postoperatively

We feel that, although this series of cases is too small to draw accurate conclusions, it will serve to aid the anesthetist to evaluate better the operative risk of the patient

#### Discussion

Dr Edward R Loftus.—It has been demonstrated repeatedly that the patient with firmly healed pulmonary lesions is a no poorer operative risk, from the standpoint of reactivation of his tuberculosis, than the individual with evidence of pulmonary scars, who never had manifest signs of the disease

This fact, which is overlooked so often, is again shown in this study in which no case of arrested disease showed evidence of extension. The group which did show extension is so small that accurate conclusions cannot be drawn. More important, perhaps, is the relatively larger number of patients in all stages of active disease who did not spread after all types of anesthesia and surgery.

To analyze the 31 instances in which extension occurred and the cause for their desemination is difficult. The difficulty lies in the inability to divorce the effects, if any, of the anesthesia from those

of the surgery In a general sense, the analysis of the cause of tuberculous extension is dependent upon many closely albed and intermingled factors. In this series each case was classified on the basis of clinical evaluation at the time of surgery as well as by the pathologic type of disease present. This latter method is of the utmost value for the prognosis is in a large part dependent upon the extent and type of disease present. Exudative disease is the soft pneumonic type of lesion. It is the acute or recent infiltration against which natural resistance has not or cannot react by the formation of fibrosis. The progression of exudative disease is of more serious import than in other types. I do not infer that these soft lesions invariably progress to a confluent overwhelming pneumonia, for the natural reastance at any time may reach the point where the process is reversed and the lesion absorbed or the process of healing by fibrosis occurs.

However massive exudative disseminations are most typical of the disease as seen in negroes and the prognosis in these instances, in general, is poor

A combined type of lesion, constituting over 50 per cent, was the most common one found in this series. Exudative-productive disease in which soft areas of disease with coexisting tendency to healing constitutes the large proportion of all cases of pulmonary tuberculosis. Although it was found that 12.3 per cent of these cases showed extension, it is safe to say that in most instances this process was reversible in contrast to the 20 7 per cent of cases of exudative disease from which most cases expired. Chronic productive disease is characterized primarily by extensive fibrosis and in these instances, though extension occurred, the ultimate prognous as to life was good.

Extension was seen to have occurred with all types of anosthetic agents and was not proportionately predominant in any one type. Ether anesthesias were followed by 25 per cent extension, but to attempt to draw conclusions on 8 cases is impossible. It does appear, however that the mechanism of spread is dependent upon other factors to which the anesthetic administration contributes only second arily Far advanced and moderately advanced discase constituted over 80 per cent of the entire series. In these instances additional pathologic processes may be acting. Cavitary disease is one of the most important of these.

Large numbers of organisms present in these excavations serve to seed remaining lung tissue when optimum conditions exist. In the absence of adequate preoperative drainage, such seeding is a constant threat.

The presence of collapse therapy seems to afford some slight but significant protection to the patient. The value of collapse would appear to be in the closure of cavitation with decrease in quantity of sputum and the number of organisms, thus avoiding the pooling of this infected sputum in undeseased portions of the lung.

Extension is, in part, dependent upon these factors presented. Alterations in physiology induced by anesthesis allow their action not by direct action. but rather by proventing the usual elimination of infected material.

Avoidance of the general conditions mentioned should aid in preventing postoperative dissemination of pulmonary disease. It seems logical that ad herence to the following points would prove useful

- Preoperative postural drainage by the patient or bronchoscopic aspiration particularly in the presence of cavitary disease
- 2. Placing the patient in a position which will prevent gravitational drainage to the less diseased lung during surgery
- 3 Frequent aspiration of traches to remove this material
- Smooth induction and rapid recovery of cough reflex, with postoperative bronchoscopy if necessary to remove tenacious secretions
- The avoidance of 'overnse of analysis postoperatively that decrease the cough reflex or raise the threshold of the reflex

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#### LACK OF VITAMIN A FOUND RELATED TO TUBERCULOSIS

A relation between lack of vitamin A and susceptibility to tuberculous, at least in rate and mice has been discovered by Drs. A. B McCoord, C. P katsampes, E. Day and S W Clausen of the University of Rochester School of Medicine.

The stores of this vitamin in the tissues of mice are lowered by inhalation tuberculosis, the doctors reported at the meeting in Atlantic City of the Amer ican Academy of Tuberculosis Physicians.

Rats that do not get enough vitamin A, they also found are more susceptible to disease than rats with high stores of the vitamin.

Animals lacking vitamin A have brouch that are

broader and more irregular in outline than those of animals not lacking the vitamin and evidences of pneumonia and bronchitis with inflammation are more evident.

-Science News Letter, June 21 1947

## DIFFICULTIES IN THE DIAGNOSIS AND TREATMENT OF LESIONS OF THE PYLORIC ANTRUM\*

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(From the Departments of Medicine and Roentgenology, the University of Rochester, School of Medicine and Dentistry)

THE importance of early diagnosis of carcinoma of the stomach makes necessary the careful evaluation of any changes occurring in The cause of these varithe pyloric antrum ations may be difficult to determine by x-ray, gastroscopic, laboratory, and clinical study, and its incorrect interpretation can lead to errors in the application of correct therapy This paper, using illustrative cases, outlines the difficulties of diagnosis, re-emphasizes the importance of careful evaluation of the results of the above diagnostic procedures, and stresses especially the thorough follow-up of suspicious cases If these methods fail to rule out the possibility of malignancy, then surgery is indicated even as a further diagnostic procedure

The pyloric antrum is considered as that part of the stomach extending from the angulus through the pylorus. Conditions in this region which may produce subjective symptoms, or objective signs, or both, may be due to one or more of the following variations. (1) normal change in size of the rugae, (2) pylorospasm, (3) gastritis, (4) benign pyloric hypertrophy, (5) gastric ulcer, (6) carcinoma, (7) benign tumors, (8) lymphosarcoma, (9) syphilis, and (10) tuberculosis.

For practical purposes the differential diagnosis usually lies between carcinoma, benign ulcer, and such benign lesions as antral gastritis and pylorospasin. That difficulties have been encountered by others is attested by the many papers that have been written on this subject 1-3

Prior to the use of the gastroscope, Camp¹ and Kirklin⁵ were among the first to emphasize the importance of careful \ray examination, especially compression technic to outline the antral mucosa. Somewhat later Golden⁵ stressed the importance of normal progression of peristaltic waves through the antrum (antral systole). With the advent of the use of the flexible gastroscope in 1932 Schindler, Moersch, and others definitely showed that the direct visualization of the gastric mucosa adds to the ability to make better differential diagnoses of these gastric lesions.

Bockus, Pollard and Cooper, 10 and Vaughn 11

Presented at the 141st Annual Meeting of the Medical Society of the State of New York, Buffalo, Section on Gastroenterology and Proctology, Wednesday, May 7, 1947 \* Supported by a Special Gastrontestinal Research Fund stomach may have similar symptoms and physical signs. This throws the burden of differential diagnosis on the laboratory, x-ray, and gastroscopy, each of which may give inconclusive findings on any single examination. Thus repeat studies are essential in arriving at a correct diagnosis.

Vaughn<sup>11</sup> and Schindler<sup>7</sup> also stress the pertinent fact contrary to the opinion of many

in 1945 presented excellent critical reviews on

portant point that different diseases of the

They each emphasized the im-

Vaughn<sup>11</sup> and Schindler<sup>7</sup> also stress the pertinent fact contrary to the opinion of many that in well-trained hands a gastroscopic examination is not so formidable as commonly thought

#### Case Reports

this subject

The 9 cases reported are divided under 3 headings

1 Changes Due to Carcinona of the Pyloric Antrum

Case 1—A married man, aged 56, entered Strong Memorial Hospital on February 9, 1943. He presented symptoms of crampy pains in the right upper quadrant which had begun six months ago. Temporary relief had been attained on a medical regimen. Appetite was now poor and the patient had lost 10 pounds.

The laboratory findings of blood, Wassermann, urine, and stools were all negative Gastric analysis showed no free hydrochloric acid after histamine X-ray findings on July 21, 1942, showed clongation of the pylorus This was not observed fluoroscopically (Fig. 1) It was regarded as suspicious and a recheck was suggested

On August 17, 1942, similar findings were present and interpreted as possibly due to adhesions since a cholecystectomy had been done, but recheck was suggested again. On February 11, 1943, the deformity noted in the pyloric antrum had increased in size and a definite diagnosis of carcinoma of pyloric antrum was made (Fig. 2)

In the gastroscopic findings on February 5, 1943, the antrum appeared narrow and its mucosa was thickened, coarse, and granular. The angulus was rigid. The gastroscopic impression was gastritis although a carcinoma could not be ruled out.

Operative finding of the patient operated upon on February 16, 1943, revealed constricting carcinoms of the pylonic antrum. Metastases were present in the omentum and in the jejunal mesentery. A subtotal gastrectomy was performed by Dr. W. J. Merle Scott.

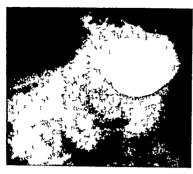


Fig 1 July 21 1942. Elongation of the pylorus not observed fluoroscopically

The microscopic findings revealed wildly growing groups of epithelial cells with irregular alveolar arrangements infiltrated deeply into the muscularis mucosa.

Comment —This case shows the importance of repeated x my examination and the necessity of operating on a lesion of the pyloric antrum which demonstrates progressive changes. It emphasizes that a normal blood count without knowledge of the blood volume may be misleading, and that the absence of occult blood in the stool does not rule out malignancy. The absence of free hydrochloric acid helps to verify a malignant lesion.

Case 2—A married man, aged 62 entered the Strong Memorial Hospital on August 27 1946



Fig 2. February 11 1943. Deformity in pyloric antrum now diagnosed as carcinoma of pyloric antrum.

Fullness and pressure in the opigastrium immediately after meals with flatulence were first noted two years before A gastrointestinal series at that time showed a suspicious area in the pyloric antrum which disappeared on a medical rogumen. His symptoms perasted. A loss of 14 pounds occurred and his appoints became poor Patient sought further medical optinon about a month before admission because his pain had become continuous.

The laboratory findings of the blood showed a mild, secondary anemia. Wassermann urine and stools were negative. Gastrie analysis revealed no free hydrochloric acid after histamine and alcohol A gastrointestinal sories done on August 30–1946 showed an ulcer of the pylorus with irregular appear ance of propyloric mucesa. Recheck was recommended because of the location of the ulcer. On September 10–1946 a repeat gastrointestinal series demonstrated narrowing and irregularity of prepyloric region which persisted after sodium amytal. The x ray diagnosis was carcinoma of pyloric antrum.

An operation done on September 29 1946 revealed a mass the size of an orange in the stomach. This had extended so that it involved the transverse colon A subtotal gastrectomy with posterior jojun ostomy was porformed by Dr. Herman Pearse

The microscopic slides showed carcinoms of the stomach with metastases to regional lymph nodes.

Follow-up — The patient developed a postopera tive pneumonia and died October 11 1946. Per mission for autopsy was refused.

Comment—Two years before the present hospital admission this patient was considered not to have a carcinoma morely because the second gastroin testinal series did not confirm the first x ray im pression of carcinoma. This points out that amy single gastrointestinal series does not alliminate the possibility of carcinoma and that x ray examinations should be repeated in all patients with persistent symptoms in spite of any single negative gastrointestinal series. This case again demonstrates that the absence of occult blood does not rule out carcinoma of the stomach and the absence of free hydrochloric acid after histamine should make one suspicious of carcinoma.

II Changes Due to Antral Gastrilis or Abnormal Rugae

Case 5—A man widower aged 61 was first seen in a private office on March 1041 Symptoms consisted of gnawing pam in the upper abdomen occurring two hours after meals and awakening patient at night Patient's symptoms recurred in April, 1046 at which time relief was gained by food and soda

Laboratory findings of the blood Wassermann, urine and stools were all negative Gastric analysis revealed free hydrochloric acid.

A gustrointestinal series was done on April 2, 1941 and demonstrated a narrowed pyloric antrum with large buarre rugal folds (Fig 3). Peristalsis appeared normal. The oral cholecystogram failed to show the gallbladder. On September 21 1046 a gattrointestinal series showed the same mucesal

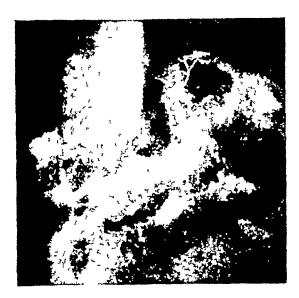


Fig 3 April 3, 1941 Pyloric antrum narrow, large bizarre rugal folds

pattern which persisted after the use of 0.4 Gm sodium amytal by mouth (Fig. 4)

Follow-up — The patient was last seen on March 25, 1947, at which time he was symptom free on a medical regimen

Comment.—This patient demonstrates giant rugae and antral narrowing which has remained constant for six years. The ulcer-like symptoms probably have resulted from the occurrence of superficial erosions. The persistence of x-ray change after sodium amytal suggests an hypertrophic or infiltrative lesion rather than spasm.

Gastroscopy was refused The presence of free hydrochloric acid, x-ray changes which did not progress during a period of six years, and disappearance of symptoms on medical regimens allow the continuation of further medical care This patient should be followed at regular intervals

Case 4 —A single man, veteran, aged 29, was first seen in a private office in August, 1946. For one year he had noted a lump-like feeling in his epigastrium five to ten minutes after meals which also awakened him at night. This symptom was relieved by milk or vomiting. His appetite was poor and he had lost 16 pounds.

The laboratory findings of the blood, Wassermann, urine, and stools were all negative Gastric analysis showed free hydrochloric acid after alcohol. An oral cholecystogram was negative. On August 31, 1946, a gastrointestinal series showed a narrow pyloric antrum with an irregular greater curvature probably due to abnormal rugal pattern. On September 10, 1946, a repeat gastrointestinal series after 0.4 Gm. sodium amytal by mouth demonstrated no change. On January 10, 1947, a gastrointestinal series, done at the Genesee Hospital, revealed the same findings

Gastroscopic findings consisted of large, edematous granular folds Impression was hypertrophic gastritis

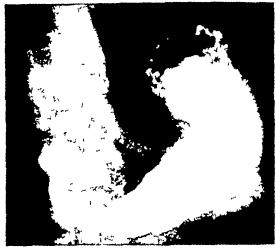


Fig 4 September 21, 1946 Coarse mucosa pattern which persisted after 0.4 Gm sodium amytal by mouth.

Follow-up—On March 4, 1947, there was definite improvement in symptoms on a medical regimen

Comment.—This case represents a patient with symptoms simulating peptic ulcer whose gastro-intestinal series showed bizzare giant rugal pattern. No change in the pattern occurred after sodium amytal. This points to a hypertrophic gastritis, or an infiltrative lesion, rather than spasm. The failure of progression, the presence of free hydrochloric acid, and the disappearance of symptoms all favor a diagnosis of a benign lesion. Follow-up, however, must be continued.

Case 5—A married man, aged 54, entered Strong Memorial Hospital July 8, 1945 Episodes of gnawing pains in the epigastrium relieved by food and powders had been present over a period of six years. The laboratory findings of blood, Wassermann, urine, and stool were all negative. Gastric analysis showed free hydrochloric acid after alcohol.

On July 10, 1945, an oral cholecystogram revealed normal concentration of the dye On July 11, 1945, a gastrointestinal series showed slight narrowing and irregularity of the pyloric antrum. The duodenum was negative. On November 23, 1945, coarse rugae were demonstrated again in the distal antrum. On February 16, 1946, the gastrointestinal series was repeated and showed the same pattern.

Gastroscopic findings of the pylorus were negative Antral waves were present. The antral mucosa was reddish brown and showed increased high lights. Impression was mild antral gastritis.

Follow-up—The patient's symptoms disappeared on usual medical regimen. On March, 1947, he was still symptom free

Comment —A long history, presence of free hydrochloric acid, gastroscopic findings, and lack of progressive changes in the repeated gastrointestinal series point to an absence of a malignant process. The follow-up in this case is adequate and should be continued.

Case 6—A man widower aged 63 was admitted to Rochester Municipal Hospital May 2 1044 He gave a ten year history of episodes of epigastric pain two hours after meals, relieved by food Two at tacks of massive gastrointestinal hemorrhage had occurred. Exploration for the above symptoms in 1030 at another hospital revealed no lesion in stomach or duodenum

The laboratory findings of the blood showed a mild, secondary anemia. The Wassermann and urine were negative Stools were four plus guaiar, and a gastric analysis revealed free hydrochloric acid.

N-ray findings on May 22 1944 showed suspicious narrowing and Irregularity of the pyloric antrum (Fig. 5) On June 8 1944 the pyloric antrum was still narrow and Irregular On January 9 1945 the pyloric antrum was floxible and it was interpreted as benign. On September 10 1946 a narrowed pyloricantrum, which relaxed slightly after sodium amytal was demonstrated (Fig. 6)



Fig. 5 May 22 1944 Suspicious narrowing and irregularity of pyloric antrum

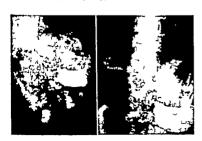


Fig 6 September 16, 1946 Narrowed pyloric antrum relaxed slightly after sodium amytal.

The gastroscopic findings on June 23 1944 demonstrated normal penstalsis in the antrum The pylorus was visualized and normal. A small ulcer with a white base was present in the lesser curva ture region of the antrum. On February 9 1945 the gastroscopic examination was repeated and the nucera was dull rod in color. No ulcer was seen The impression was chronic gastritis. The follow up on March 21 1947 revealed no symptoms to be present.

\*Comment —It is hazardous to pursue a medical regimen in this type of case The justification for continuous medical regimen was the evaluation of the previous negative exploration, the negative gastroscopic examinations, and the relaxation of the antrum after oral sodium amytal Close observation must be continued and, if ulcer symptoms recur this patient should have a subtotal gastrostomy

III Miscellaneous Lesions of Pyloric Antrum
(a) Pylorospasm

Case 7—A man, aged 52 entered the Rochester Municipal Hospital on August 12 1946 complaining of intermittent nausea, womting, and a burning prigastric pain which began after separation from his wife nine years ago. The pain and vomiting had increased during the six months prior to admission. Repeated gastrointestinal series had been done because of a sundicious leagon in the pylorus.

The laboratory findings of the blood, Wassermann and urine were negative Stools were one plus guaiac. Gastric analysis showed free hydrochloric acid. The x ray findings on June 25 1946 showed a persistent prepyloric narrowing, considered probably malignant although one film was apparently nor mal. (Figs 7 and 8) On December 17 1946 a gastrointestinal series still rovenled the prepyloric narrowing After administration of 0.4 Gm sodium amytal by mouth the stomach appeared normal

The gastroscopic finding on June 28 1946 visual-



F10 7 June 25, 1946. Persistent prepyloric nar rowing considered as probably malignant.



Fig 8 June 25, 1946 Apparently normal propyloric region

ized an atrophic gastritis with erosions. The operative finding on August 16, 1946, of the patient, who was explored by Dr Richard Woodruff, was an edematous gastritis. A congenital band appeared to extend from the cecal region to the duodenum A questionable old scar of a healed ulcer in the pyloric region was present. The congenital band was freed.

Follow-up —On April 1, 1947, the patient's domestic situation had improved, and he had practically no gastrointestinal symptoms

Comment—This case represents a pylorospasm on a psychogenic basis. An operation had been performed because of a persistent defect in many of the gastrointestinal series. The proper evaluation of the gastroscopic findings and the disappearance of spasm after sodium amytal might have avoided surgery. The cessation of spasm after sodium amytal points to its cause on a psychogenic basis.

Case 8 —A married man, aged 50, entered Strong Memorial Hospital on June 26, 1935, for symptoms simulating peptic ulcer with obstruction He was admitted again on August 29, 1938 An operation The last admission was revealed no pathology on December 28, 1945 Symptoms of peptic ulcer with obstruction had increased (1,000 ml of stomach contents were aspirated) The laboratory findings of the blood, Wassermann, urine, and stool were negative Gastric analysis showed free hydrochloric acid X-ray findings on June 28, 1935, showed prepyloric and duodenal ulcers associated with gastric retention On December 11, 1945, a gastrointestinal series revealed a gastric ulcer on the lesser curvature of the cardiac portion An ulcer in the region of the pylorus with obstruction also was thought to be present (Fig 9)

A benign ulcer crater in the lesser curvature of stomach penetrating into liver was found only after opening the stomach. The pylorus and duodenum were negative. A subtotal gastrectomy was performed. The follow-up on January 10, 1947, revealed that no symptoms were present.

Comment—This patient during his last hospital admission was clinically diagnosed as a benign gastric ulcer with obstruction secondary to a lesion in



Fig. 9 December 11, 1945 Gastrointestinal series interpreted as gastric ulcer on lesser curvature and ulcer in region of pylorus with obstruction



Fig 10 November 5, 1945 Defect in lower antrum suggesting external pressure or polyp

the region of the pylorus This had escaped notice previously even during exploration. It is an example of pylorospasm secondary to a benign intrinsic lesion of the stomach

Case 9 Part I—A single man, aged 64, was seen in private office on October 11, 1945, for recurrent attacks of diarrhea The laboratory findings of the blood, Wassermann, and urine were negative Stool was positive for occult blood and gastric analysis showed free hydrochloric acid

X-ray findings on November 5, 1945, revealed a defect in the lower antrum suggesting external pressure or polyp (Fig 10) From operative findings, on

February 14 1040 the abnormality seen was thought to be either a benign or a very early mallignant lexion. A Bilroth I operation (resection of the an trum, and end to-end anastomosis of stomach to duodenum) was performed. Microscopic examination revealed a submucous nedule of the pyloric portion of the stomach containing ectopic duodenal mucosa and mancreatic tissue.

Part II —Following operation the patient had 3 cpisodes of tarry stools. The diagnosis was mar ginal ulcer Thio x-ray findings of a gastrointestinal series on June 21 1916 showed porsist in narrowing in region of gastroiduodonal anastomosis which might have been infurpreted as narrowing in mid antral region. The laboratory findings of the blood revealed a mild secondary anemia. The Wasser mann and urine were negative. The stool was positive for blood and a gastric analysis showed free hydrochloric acid.

On February 6 1947 adhesions were found about the provious operative site. The adhesions were freed and a vagotomy was performed.

Follow-up —On April 5 1947 uneventful postoperative convaluecence had occurred —Stools were negative for blood and a mild diarrhea was still present

Comment — Surgery was performed upon this patient because a routine gnatrointestinal serior revealed a persistent lesion in pyloric antrum. The diagnosis of pancreatic rest was made only after microscopic section. Following the Bilroth I operation in this nonpeptic ulcer patient a bleeding, mar gunal ulcer developed. Vagotomy to date has prevented a recurrence of the nelena.

#### Discussion

The foregoing cases demonstrate the problems that were encountered in patients with lesions of the pylonic antrum

The first case illustrates an antral lesson demon strated by x-ray, that was followed too long The care of the patient was influenced by clinical improvement and stools were negative for blood This patient, because of the nature of the x ray findings should have had his eastere analysis and gastroscopic examinations sooner Regardless of these procedures this is the type of lesion which may require early surgery even as a diag nostic measure. It is important again to em phasize that a suspicious gastrointestinal series is very significant and should not be disregarded merely because a succeeding gastrointestinal series is reported as negative. The antral region is one of the easiest portions of the stomach to visualize by x-ray, but the most difficult to analyze from the differential diagnostic view point

The findings in the second patient also stress the fact that caremoma of the stomach can grow slowly Kantor<sup>12</sup> and others<sup>13</sup> <sup>14</sup> have reported similar lesions. In both of these patients mere reliance on stools would have been misleading The 4 cases reported here, in which the final diagnosis was antral gastrius or large rugae, required close observation and complete study including gastrontestinal series, gastroscopy (except in the patient who refused), gastro analysis etc., to allow continued medical observation. The viray findings in 2 of these cases simulate abnormal rugae recently reported by Ricketts et al. 13. These patients must be observed carefully to evaluate the proper therapy

Pylorospasm is divided usually into 3 types psychogenic, intrinsic, and reflex. The cases reported here represent the first 2 types, respectively. The psychogenic pylorospasm occurred following emotional stress and persisted in most of the gastrointestinal series taken during the period of symptoms. In our experience such spasm will disappear under the hypnotic action of sodium amytal. This patient could have escaped operation if these points had been considered more carefully.

The intrinsic pylorospasm persisted until the intrinsic lesion was removed. This type of pylorospasm in our experience does not disappear with the usual hypnotic does of sodium amytal but is relieved by deep anesthesia. Unless the surgeon is aware of this possibility and its complications he may not explore the stomach sufficiently to discover the organic lesion.

The change in the x-ray appearance of the py lone antrum due to a pancreatic rest required surgery and microscopic examination to establish the correct diagnosis. It is best to operate on any lesson of the pyloric antrum when there is doubt of its benign nature

#### Summary

Nine cases with gastrointestinal symptoms are reported all of whom had changes of the pylone antrum by x ray. These findings necessitated repeated observations in most cases before a diagnosis was reached. Gastroscopic examination was very useful in differentiating most of these leanons where the area could be visualized adequately. The laboratory findings alone were misleading in some cases and must be evaluated in the light of all other observations. Sodium amytal has been used in several cases in an attempt to differentiate organic from inorganic leaions and seemed to have been of value in separating psychogenic from intrinsic pylorospasm.

Careful analyses and correlation of the clinical, laboratory '-ray and gastroscopic findings, as well as repeated examinations and close follow-up, are necessary to attain a high percentage of correct diagnoses in the type of patients presented in this paper.

#### Discussion

Dr Walter Scott Walls, Buffalo -In the introduction to his paper. Dr Segal said that "the importance of early diagnosis of carcinoma of the stomach makes it necessary to scrutinize carefully every lesion that may deviate from the normal " This, of course, is a statement of prime importance when we consider that even with the very best diagnostic aids. including gastroscopy and x-ray, there is a sizable error in diagnosis in the best of hands Dr Howard Grav. of the Mayo Clinic, reports a 6 per cent error in diagnosis of gastric lesions preoperatively, and further states that at operation the surgeon and pathologist cannot be sure always of the diagnosis of a resected specimen without microscopic sec-We, too, have seen cases where the ultimate diagnosis has been in doubt for several days while the pathologist made almost serial sections of a suspicious ulcer

The burden of preoperative diagnosis falls, of course, on the internist, and unless he feels that his accumulated evidence makes surgery advisable at once, he must be willing to see not only that a lesion heals under his treatment but that it stays healed This will necessitate refor at least two years peated x-ray examinations and also gastroscopic follow-ups, too, if available Failure of a lesion to heal under vigorous medical treatment which should include rest in bed, or a recurrence of an apparently healed lesion, or last, inability to institute a proper regimen of treatment and follow-up, should be regarded as indications for surgical treatment five-year survival rates of postoperative gastric malignancy are so universally poor, that early operation is imperative if we expect to remove the lesion in a state of limited extension. It is well known that

malignant gastric lesions improve paradoxically under a good medical regimen, only to blossom forth anew as the patient and doctor are lulled to a false sense of security This is amply demonstrated by Dr. Segal in his first 2 case reports where the patients had been x-rayed and treated six months and two years, respectively, previous to surgery

Dr Segal discussed pylorospasm due to psychogenic factors and also that due to an intrinsic He mentioned pylorospasm due to reflex causes and in this connection it probably should be mentioned that cholecystic disease, certainly, and appendiceal disease, possibly, are frequent

causes of pylorospasm

There are few lesions in medicine where the diagnostician can less afford to be wrong than in the diagnosis of lesions of the stomach Segal's admonitions of careful and repeated complete studies are timely and well emphasized.

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#### PROGRESS IS NOTED IN MEDICAL STUDIES

Grants totaling \$532,000, chiefly for research in medical colleges, universities, and hospitals in the United States and Canada, were made during 1946 by the John and Mary R Markle Foundation, it was announced recently by John M Russell, executive director

The largest grant, \$60,000, went to the Committee for Research in Endocrinology of the National Research Council, the work of which for the last ten years has been supported by the foundation institutions receiving grants and some of the research

projects they will carry included

Columbia University, College of Physicians and Surgeons, \$29,000 for studies in the treatment and prevention of filariasis and of the vitamin E content of human and animal tissues, Cornell University Medical College, \$32,000 for studies of the influenza virus, hypertension and myasthenia gravis, Johns Hopkins University School of Medicine, \$24,000 for research on cholesterol and ocular tuberculosis, Harvard Medical School, \$22,000 for studies of hypertension, hypersensitivity, and altitude sickness, McGill University, \$11,000 for studies of red blood cells during storage and after transfusion, University of Minnesota, \$9,000 for studies of the brain, University of California, \$13,000 for research in tussue metabolism and studies of blood.

Mr Russell pointed out that the attitude of the public toward "slow, deliberate, basic studies in the sciences," is responsible for increased funds for re-

search

"Recognition by the citizen of the importance of basic science has made it possible to support research from funds coming directly or indirectly out of his pocket," he said "Agencies which collect funds from the public to combat a single disease and which once thought they could take only palliative measures now are spending a great deal of money to strike at the very root of the problem Public funds in unprecedented amounts are being allocated to institutions for medical research, both public and private"

#### ANAL INCONTINENCE

STUART T Ross M D Hempstead, New York

A LTHOUGH actual cases of rectal incontinuous nence are few, the profound nature of the social consequences to the patient warrants the careful consideration of the profession toward this condition. Rare indeed is a nonfatal, non crippling disease which can ruin a life as effectively as a true incontinence of feees.

#### Etiology

Broadly speaking, causes of meontinence may be divided into (1) trauma to the local musculature meduding surgical trauma, (2) disturbances of in nervation, and (3) congenital malformations

Clinically, however the eurology of the great majority of cases of incontinence falls into one or the other of the following specific categories

- 1 Incontinence following operation for fistula (Case 1)
- 2 Incontinence following a third degree tear during partirition (Case 2)
  - 3 Tabes dorsalis
  - 4 Injuries to the spinal cord

A smaller number of cases are found following

- 1 Overstretching of the sphincter at operation (Case 3)
  - 2 Sodomy
- 3 Direct trauma, i.e. impalement or war wounds

#### Prophylaxis

As as well known, continence of feces depends upon the integrity and adequate functioning of the external sphincter of the anus plus the puborectalls portion of the levator ani The internal sphincter is merely a terminal thickening of the inner circular smooth muscle coat of the rectum and is of little importance in the maintenance of control. Prophylaxis of incontinence consists in efforts to preserve the physical integrity of the external sphincter and a functioning nerve supply To the obstetrician this means an avoid ance of third degree tears and their prompt repair when these occur To the anorectal surgeon it means abandoning the practice of forcible divul sion of the sphincters—a brutal, dangerous and unnecessary maneuver Furthermore during fistula surgery, the following rules for sphineterotomy should be observed

1 The sphincter should be cut in one place only The dangers of multiple incisions at one sitting should be obvious.

2 Sphincterotomy should be performed in the midline posteriorly if possible. This is for several reasons.

CHAIL LOSTSOTTS

(a) The greatest thickness of muscle is here(b) The superficial portion of the external

sphincter will be separated and not cut by such an incision

3 The subcutaneous external sphineter alone may be severed with impunity

4 If necessary, the greater part of the external spluneter may be severed, provided that enough muscle is left to act as a splint for the remainder

5 Muscle ends should not be packed apart. The natural tendency will be to heal with a short block of scar tissue between sphineter ends, but if these ends are held apart for a number of days by packing the resultant large creatrix will prevent their near apposition, and incontinence of some decree may result.

If it is found necessary to divide the entire anorectal ring, it may be done with a two-stage seton technic. The sphincter is divided from the inside part way toward the anal verge, and the remaining muscle, composed of the subcutaneous and part of the superficial muscles is surrounded by a loose heature of heavy black silk called a seton. When the operative wound has healed down to the seton, it may be removed by incising the remaining sphincter thus completing the sphineterotomy This technic utilizes the superficial parts of the sphincter as a splint for the severed deep parts when the latter are healed, they in turn serve as splints for the severed superficial parts

Case 1—R. G., a white man of 42 was admitted to the hospital with a diagnosis of abscess above the levator ani on the left (left pelvirectal abscess). He was treated conservatively for two days, becoming more and more toxic, and on the third day incision and drainage were done. Culture of the pus revealed Bacillus coli.

Seven months later this patient was operated a tract was found extending from the posterior anal commissure around the left side of the anus, crossing the midline anteriorly and into the right ischioanal space. The tracts were incised down to the internal opening, which necessitated severing the external sphincter. The wound was packed with

Presented at the 141st Annual Meeting of the Medical Society of the State of New York, Buffalo Section on Gastroenterology and Proctology Thursday May 5, 1947

iodoform gauze packing" The wound remained packed open for nine days, being repacked 5 times in that period

Five weeks later the patient was readmitted with a complaint of partial incontinence ever since the operation for fistula. Gas and a small amount of stool frequently escaped without the patient's volution A fistulous tract was still present Some weeks later a Devine type colostomy was done, and two months after this a perineal dissection was undertaken, during which scar tissue was excised and "dead space resulting from excision of scar tissue obliterated by interrupted silk sutures except for a pocket in the posterior midline which was packed" Two days postoperatively the packing was removed and the pocket repacked This procedure was repeated daily for two weeks

Of the many aspects of this case, two deserve particular mention First, the two-day delay in the hospital before the initial incision and dramage of the abscess undoubtedly permitted the abscess cavity and the subsequent fistula to increase in size Second, the assiduous packing and repacking of the fistulous wound was inadvisable

#### Diagnosis and Examination

The diagnosis of incontinence per se could hardly be mistaken However, the determination of the etiology and of the immediate status of the sphincteric mechanism is important to the planning of a corrective procedure

With incontinence following fistulectomy, the resulting scar will point infallibly to the general location of the muscular defect Careful palpation with one finger in the anus and the thumb at the verge will usually then disclose the location of the intact portion of the muscle

In complete obstetric tears of the anterior quadrant, the ends of the retracted muscle may be indicated by slight skin dimples—the so-called "sphincter pits" Palpation as described above will locate the intact portion of the muscle

In incontinence resulting from forcible divulsion, the sphincter will be intact and palpable throughout, but its contractile excursion will be insufficient to close the aperture effectively. This is illustrated in Case 3

In incontinence resulting from tabes or other neurologic conditions such as cord tumor or traumatic transection of the cord, the anus will gape when lateral traction is applied to the edges

#### Treatment and Case Reports

The treatment of anal incontinence is opera-Several satisfactory technics—some new, some old-are available for use in the various conditions as found clinically

The oldest procedure and the simplest in concept consists merely in dissecting out and removing the scar tissue from between the several sphincter ends and suturing these ends together

While from a theoretical standpoint this may be sound, there are technical difficulties inherent in any attempt to do accurate dissection in cicatricial tissue Moreover, the sphincter ends when freed invariably will be found to be difficult to pull together and will not hold well when sutured under tension Nevertheless, the procedure is useful in a few cases, provided scar tissue is not removed from the torn ends. More mention will be made of this point later Case 1 represents an example of this type of operation

Cases of incontinence due to obstetric trauma and accompanied by laceration of the rectovaginal septum are probably best treated by turning down a vaginal flap and suturing the spluncter ends anterior to it, a procedure modified from Farrar's technic 1 This may be illustrated by the following case

Case 2—S W, a white woman of 29, was first seen in April, 1942 Ten days previously the patient had been delivered of her first baby following an extremely difficult seventy-two hour labor with a right mediolateral episiotomy and forceps. The episiotomy extended through to the rectum mediate repair was done using chromic catgut and closure was apparently firm up to the seventh postpartum day, when an oil enema was given followed by a low soapsuds encina That night fices were passed through the vagina

Examination revealed the episiotomy to be completely broken down except for a one-quarter inch bridge of skin at the fourchette. The external sphincter was completely severed just to the right of the anterior midline. The walls of the wound were soiled with stool and lined with granulation tissue A delay of several weeks was recommended to permit the patient to recover from her strenuous delivery During this time, measures were taken to decrease the infection and, are weeks later, the folfowing note was made on the office chart

"Examination reveals the present status to be as With a finger inserted in the anus, no constriction whatever is felt when the patient is asked to contract the sphincter The external sphincter muscle is palpable throughout the entire extent of the anus except for one-half inch, anter-At this point, rectal mucous membrane ends in scar tissue which is joined directly to the vaginal mucous membrane A bridge of tissue, oncquarter inch thick, remains, marking the original position of the fourthette Between this and the anterior aspect of the rectum as it joins the vagina is a circular defect 1 cm in diameter"

At operation, the bridge of tissue was severed The posterior end of each labium minus was sutured to the medial surface of the corresponding thigh, thus furnishing automatic traction. An incision was made on either side from the lateral edge of the rectovaginal septum upward for one inch, and the upper ends of the 2 incisions were joined across the posterior wall of the vagina The flap of vaginal mucosa thus outlined was dissected free and turned

down Each lateral incision was extended posteriorly and the scar tiesue over the sphineter ends freed for one-half inch and sutured togother anterior to the reflected vaginal flap with number 0 chromic catgut. The puborectales were approximated across the midline. Wounds were loosely closed and small rubbor tiesue drains left at the apex of the vaginal wound

The right wound healed by first intention but the left wound opened somewhat and healed by granulation Following this procedure, the patient lost a small amount of gas occasionally but otherwise control was good.

For patients whose splineters have been over stretched and for those whose incontinence is the result of a small amount of sear tissue between muscle ends, a plication or recting operation is most satisfactory. This is most conveniently done in the anterior quadrant.

Case S—D L. a white man of 74 a clergyman twenty five years previously had been subjected to hemorrhoidectomy Since this operation he had been afflicted with incontinence for liquid stools and gas but could retain solid stools faurly well. Five years following the hemorrhoidectomy the patient noticed a gradual onset of diarrhea and from that time on had an average of 4 stools daily all of them liquid except for an initial plug of solid stool in the morning. There had been no change of this lower habit for two years. There were no further symptoms, but the more or less constant dribbling of liquid stool played profound havec with the patient shife.

At examination, there was noted considerable laxity of the external sphineter the anorectal line being easily brought into view by lateral traction on the buttocks. Palpation revealed a hypotonic sphineter with no apparent loss of continuity Upon request the patient could contract the sphine ter but the contractile excursion was insufficient to close completely the anal aperture. Liquid stool lined the walls of the rectum.

Hydrochloric acid by mouth cleared up the diarrhea, and after a suitable workup considering his age the patient was operated upon. A semi-circular incision was made encirciling the anterior half of the anus one linch from the anal verge. The skin flap thus outlined was dissected up and drawn back over the anus, exposing the anterior portion of the aphanoter With the assistant's hitle finger in the anal canal 3 interrupted number one chromic catgut sutures were placed transversely uniting the right and left portions of the muscle so that the finger fitted snugly but not tightly into the canal. The akin flap was sutured back in place with interrupted silk. The results of this simple procedure were excellent, including good control of gas.

In addition to the above methods we are in debted to Blaudell's for the following procedure useful for cases presenting large defects of the sphincter with the remaining muscle markedly

contracted The location and extent of the remaining sphineter is ascertained by palpation by finding the dimples marking the aphineter ends and by observing the contour and wrinkling of the aperture A semicircular incision is made about the site of each muscle end and deepened From the convexity of each incision a one to two em longitudinal incision then is made parallel to the and verge and deepened to the same depth No attempt is made to dissect out the muscle Each block of tissue containing a muscle end is then sutured to the further end of the longitudinal incision thus advancing it for a distance equal to the length of the incision Deep sutures are inserted to avert wound tension. This constitutes the first stage of the operation and serves to elongate the contracted muscle and to bring its ends nearer together. At the second stage, after firm healing, a circumfer ential curved incision is made from one of the previously formed scars to the other-that is. from one muscle end to the other The 2 ends of the incision are then approximated, thus bringing the muscle ends again into near approximation, and at the same time forcing a fold of tissue toward the anal aperture itself thus filling some of the gap Although this procedure leaves a scarred and nuckered anus its functional results should be good and it has the further ad vantage of comparative simplicity

vantage of comparative simplicity
Numcrous other operative procedures have
been advised for the relief of incontanence. Most
of these attempt to construct a substitute splineter from strips of fascia lata or nearby muscles.
The usefulness of such operations is limited
sharply by the fact that they necessitate retraining the patient to contract relundarily his
glutei adductor magnus, or whatever muscle
has been utilized. In other words, continence
following these operations will be to some extent
under the control of the will but will definitely
not be foolproof and will require alertness.

In hopeless cases of complete absence of sphincter or transections of the spinal cord, the patient should be treated as though an abdominal colostomy were present—i e. with a constipating diet and daily enemas or prigations

Several principles of operation will bear empliasis.

- It is well to make no attempt to dissect sear tissue caps completely away from torn
   muscle ends. These caps are firmly attached to the muscle and serve to hold sutures with out strangulating.
  - 2 When the sphineter muscle is contracted and thickened it should be united in stages thus permitting it to lengthen between stages without the disastrous results of suturing under excessive tension

- 3 Steel alloy suture material has several advantages, among which are its failure to irritate tissues and its holding qualities in a contaminated wound. I am convinced that the recovery of Case No. 2 would have been facilitated by the employment of steel instead of catgut.
- 4 It is not always necessary to remove a short block of scar tissue—narrowing the muscular ring is simpler and will often serve as well

# Summary

- 1 Common causes of anal incontinence are enumerated
- 2 Principles for avoiding incontinence in fistula surgery are discussed
- 3 Methods of operative therapy are described
  - 4 Illustrative cases are presented

### Discussion

R. V Gorsch, M D, New Yorl —Dr Ross has presented the subject of anal incontinence primarily from the proctologic standpoint, emphasizing the prophylactic measures in fistula surgery and the more recent methods of sphincter repair

Fistulectomy, incisional drainage of anorectal abscess, and hemorrhoid operations are accountable for roughly 60 per cent of the cases of anorectal incontinence. The vast majority of these cases are avoidable and the following remarks are directed primarily to this phase of the subject.

Repeated fistulectomies or fistulotomies result in anorectal incontinence because division of the sphincter musculature is commonly done without sufficient regard to the anatomic divisions of the muscle and its functional capacity in its various quadrants, particularly the anterior in the female Furthermore, division of the sphinoter muscles is commonly made on an incomplete conception of the fistula pathology-namely, missing the original pathologic internal opening This is perhaps the commonest cause for recurrence The proctologist and the general surgeon are repeatedly confronted with the problem of demonstrating the internal opening of fistula, and in a considerable number of cases repeated attempts, despite the methods used, injection, probing, x-ray, etc, fail to reveal any connection with the bowel The anticipated disclosure of the internal opening during operation frequently enough is disappointing, and the common practice of puncturing the bowel wall and dividing the intervening musculature at the probable site of the internal opening is an uncertain procedure We strongly question the advisability of incising the sphincters at any level or making drainage incisions with the idea of shortening fistulous tracts. or with the hope that "nature" will take care of the internal opening The increasing difficulties confronting subsequent operators, both in the ultimate cure of fistulas and the successful repair of incontinent sphincters following successive recurrences scarcely need be mentioned

Successful surgery of anorectal fistulas depends essentially on the accurate determination and actual demonstration of the entire fistulous tract and its internal opening in relation to the anorectal muscle ring. When these criteria are fulfilled the surgery is usually successful.

In the tuberculous fistulas and those secondary to the chrome collides and regional ileitis, these considerations are of greater significance. In this regard perirectal sinuses following suppurative processes which are entirely unrelated to the bowel should, if possible, be carefully differentiated and not treated as anorectal fistulas. Misdirected treatment in these cases usually results in repeated recurrences, chromic invalidism, and incontinence

Drainage of anorectal abscesses has a definite bearing on incontinence. The pathogenesis of anorectal suppuration and fistula formation is still somewhat controversial, but that adequate drainage has not always been done on a basis of accurate localization seems to be substantiated by the recent work of Dr Courtney Incisions of the sphincter musculature in draining anorectal abscesses should therefore be cautiously advised and carned out In selected cases and in expert hands it may perhaps be permissible to include the intramuscular portion of the abscessed tract in the drainage incision, with the expectation of avoiding a subsequent fistula. Injudicious probing may complicate materially the future fistula pathology, and it may be noted in this regard that all anorectal abscesses are not necessarily of cryptic or intramuscular gland origin

Under etiology, the incontinence commonly resulting from procidentia of the rectum should be mentioned. A certain degree of improvement may follow correction of the procidentia but the attenuated anal musculature usually requires operative repair. Multiple plication of the sphincters and levator an muscle with perincorrhaphy in the female would appear to be the method of choice.

Also under etiology, the varying degrees of incontinence following preservation of the sphincters in the abdominoperineal excision of the rectum or sigmoid may be mentioned

In the surgical treatment the author stresses the inherent difficulties of accurate dissection of the anal musculature in scarred tissue, and he presents the technic of the various surgical procedures in detail I desire to stress some of the physiologic factors

Successful repair of the anorectal musculature requires a careful evaluation of several factors. The more important of these include the tone, contractility, and extent of musculature still intact, including the levator ani and their innervation. Most important is the extent of actual or residual infection which is directly related to the capacity of the tissues for successful healing. The approximation of scarred sphincter ends or scar tissue in general produces a closed wound which presents immediate problems of adequate wound nutrition,

tissue mechanics, and "physiologic antisepsis

(Flaming)

Favorable conditions for these assentials of primary wound healing do not exist in the anorestal tissues, particularly in recurrent cases, and tissue disruption with bridging and sinus formation usually follows. These factors account for the poor results in the so-called classic operation of approximating the cut ends of the sphincters. They likewise indicate a definite preference for operative technics which plicate or shorten intact and undamaged portions of the musculature as originally advocated by Dr Blaisdell and described in detail by Dr Ross. In minor degrees of incon tinence, simple excision of scar tissue but without suture, as advocated by Bule, may sometimes be useful and successful. Incontinence with more or less complete destruction of the sphincters requires a special type of operation, usually with fascial transplants of the Wreden-Stone type based on the particular merits of the case.

In selected cases plication and reefing of the levator plate posteriorly and careful approximation of the pubecocoveral legs in the female may be supplementary useful procedures.

Anal incontinence arising on a medical basis is usually not amenable to surgical interference and is therefore only of diagnostic interest to the proctologist.

#### References

Farrar L. K. P: Surg., Gynec. & Obst. 50: 741 (April) 1930.

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#### TEACHING DAY TO BE HELD IN MONROE COUNTY

A Teaching Day for the Monroe County Medical Society will be held Thursday, November 13 at the Rochester Academy of Medicine. The morning assign, beginning at 11 00 A.M., will feature lectures by Dr Paul Remikoff professor of clinical medicine at Cornell University Medical College on 'The Diagnosis and Treatment of Anemia,' and by Dr Clarence E. de la Chapelle professor of clinical medicine and associate dean of New York University College of Medicine on 'Management of Acute Cardiovascular Emergenciea.'

The afternoon session, which starts at 2 00 P.M. will have as its speakers Dr George E. Anderson clinical professor of medicine at Long Island College of Medicine, Brooklyn, who will lecture on the sub-ject of 'Diabetes Mellitus, Its Modern Interpreta-tion and Treatment, Dr. Edward J Stieglitz, chief of staff of Suburban Hospital, Bethesda, Maryland, on the subject of 'Health in an Aging Population', and Dr H. McLood Rigguns, associate in medicine at Ballevus Hospital, College of Physicians and Sur geons, Columbia University and medical durector of the Tuberculosis Service at Triboro Hospital, Quoens, who will speak on "Asymptomatic Thoracia Diseases.

This postgraduate instruction is presented as a cooperative endeavor between the New York State Department of Health and the Medical Society of the State of New York.

Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity -The Mississippi Doctor June 1947

#### NEW BARBITHRATE REGULATIONS

Effective November 1 1947, the prescribing and dispensing of barbiturates in the City of New York will be governed by the following requirements of the Sanitary Code

Barbiturates may not be dispensed except on

written prescription.

2. A prescription for barbiturates may not be refilled unless there is specified on the prescription the number of times it may be refilled and the mini mum interval that may elapse between refillings.

3 Under no circumstances may a prescription

for barbiturates be refilled later than three months

after the date of usuance.

4. Barbiturates may not be dispensed on a telephone order

5 A copy of a barbiturate prescription cannot be filled only an original is acceptable.

6. Barbiturates, including manufacturers samples dispensed directly to a patient by a physician, must be given in a container on which the follow ing information appears

- (a) Doctor's name and address
- (b) Patient s name and address (c) Directions for use
- (d) Date of dispensing
- Prescriptions written for compounds containing barbiturates are exempt from the provisions of the new law if the compound contains in addition to a barbiturate such a quantity of another drug or drugs as to make the action of the compound not primarily hypnotic or somnifacient and provided no such compound contains more than 1/4 grain of a barbiturate in each dose. In addition prepara-tions used as sprays, gargles or for external applica-tion are also exempt if they contain, in addition to the barbiturate, other ingredients which make the preparation unfit for internal use.

The Department of Health is making every ef fort to acquaint practitioners pharmacists, manu facturers, wholesalers and the general public with the provisions of the Sanitary Code regulating the sale and distribution of barbiturates. If the program is to be successful, the cooperation of every physician practicing in this city is essential.

> ISRAEL WEINSTEIN Соттимопет

should be administered Doubtless it is well to recall the fatal outcome of abdominal surgical procedures during the epidemic mentioned

I can recall one case which illustrates the effect of amebae on an anorectal inflammatory process. A large ischiorectal abscess had developed which was incised and was followed by an extensive fistula in ano. Satisfactory fistulectomy was accomplished but there was no evidence of healing until antiamebic therapy was instituted and continued until the stools were free from the organisms. When this had been accomplished healing proceeded normally and without more deformity than would have occurred had there been no amebic infection at any time.

### Tuberculosis

Tuberculous ulceration or colitis will rarely cause perforation and, in the hyperplastic type, stricture may be produced In the case of a young woman, a stricture developed which caused sufficient obstruction to make colostomy im-The young woman suffered from extensive pulmonary tuberculosis and hence a presumptive diagnosis of tuberculous stricture or stricture of unknown origin was made lesion could not be distinguished grossly from one caused by venereal lymphogranuloma, but postmortem examination proved the diagnosis of tuberculous stricture to be correct Most fistulas in ano will be infected with the tubercle bacillus if there is any tubercular colitis

# Venereal Lymphogranuloma

Venereal lymphogranuloma will often produce persistent proctitis and also stricture. While this is not typically an ulcerative disease of the colon, it seems to belong in this group for study. As the name implies, the disease is infectious and is distributed by venereal contact.

The changes caused by this disease and observed in the rectum, anus, perianal region,

perineum, and labia result from the involvement of the lymphatics. The resulting lymphangitis is accompanied by the formation of excessive fibrous tissue which forms the stricture, accounts for the edema, the perianal tags, and the peculiar sinuses, as well as the elephantiasis of the vulva of some women who have this disease. The stricture observed in the rectum may be ringlike or tubular. It may develop promptly and extend rapidly or it may proceed slowly. The lesions observed may be true fistulas or only sinuses extending into the perianal tissue.

### Factitial Proctitis

Factitial proctitis which results from the application of radium to the cervix may be only superficial telangiectasia or a true ulcer. In the latter case contraction of the lumen of the rectum may occur or in some instances perforation through the base of the ulcer will cause a rectovaginal fistula. The ulcer is chronic and may persist for years

### Comment

In discussing the complications peculiar to ulcerative diseases of the colon I have tried to minimize the discussion of percentages and other details which might prove of interest only to a specialist in this field. These can be obtained from studies such as those compiled by Bargen <sup>4</sup> I have tried to present a subject worthy of consideration by all physicians and surgeons and to discuss it in a manner to insure that the patient may be protected, that the proper diagnosis may be made, and that the too-common pitfalls may be avoided

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### THE DEAR PUBLIC

Information clerks sometimes feel a little less sweet than their manner indicates. For example, the clerk at the information desk at Missouri Baptist Hospital, St. Louis, continued to wear her cordial smile after these two encounters.

MRS CALLER How is Mrs James Roberts

today?

CLERK Mrs Roberts' condition this morning is reported good, she had a comfortable night and is getting along very well MRS CALLER Is she wearing her pink night-gown or her blue one?

That was an unusual occurrence The following is a more routine reaction

MRS GUEST I'd like to see Miss Julia K Jones CLERK Miss Jones was discharged as a hospital patient and went home yesterday afternoon

MRS GUEST Oh, ISn't that a shame! Here I've made a long trip out here for nothing!—The Modern Hospital. June. 1947

#### CLINICOPATHOLOGIC CONFERENCES

FOURTH MEDICAL DIVISION OF BELLEVUE HOSPITAL, New York City

Date. December 2, 1946

Conducted by Max Truber, M D

# Chronic Bronchitis with Resulting Pulmonary Fibrosis and Emphysema

Dr. William A. Leff W P, a 50-year-old white man, was admitted to Bellevue Hospital on August 12, 1946 with the chief complaints of generalized weakness and pain in the left chest aggravated by respiration He had been transferred to Bellevue from another hospital where he had been attending its medical clime for the past three years At this clinic it was thought that he had pulmonary fibrosis and emphysema, and that he had had repeated pulmonary in farctions. A hypertension was noted also was under frequent observation at the clinic and was getting along well until a few days prior to this hospital admission when he began to complain of pain in the left chest and abdomen. This caused him to visit the clinic, where he appeared 'strikingly worse" to those having seen him previously Examination at this time revealed a blood pressure of 155/110 and a ventricular rate of 120 with normal sinus rhythm. The chest revealed numerous wheeres but no rales. and his abdomen was slightly but diffusely tender He was referred to Bellevue Hospital with the diagnosis of a possible myocardial infarction.

The past history revealed that the patient had pneumonia following measles at the age of 13 Since that time he had a persistent cough productive of approximately 250 cc. of yellow mu coid sputum daily, which became aggravated during the winter months. At 22 he had an episode of left-sided pleuring and at 23, a partial gastrio resection for a gastric ulces

Four years previous to the present admission he was hospitalized for a second episode of pneumonia. At this time it was thought he had tuberculosis, but sputum concentrates and gastric washings were all negative for acid-fast bacilli. The x ray was interpreted as extreme apical fibrous infiltrations bilaterally "His blood pressure at this time was 135/85 From the time he left the hospital until the present, he suffered frequent coughing spells anterior chest pain and wheezing, progressive dyspnea, intermittent 2-pillow orthopnea, and ankle edema. Anorexia, weakness, and frequent episodes of diarrhea also occurred There was one episode of hema turia two years ago

Physical Examination —On admission the temperature was found to be 100 F pulse,

130, and blood pressure, 160/150 The patient was cachectic and appeared both acutely and chronically ill He was moderately dyspaeic and orthopness. The eyegrounds revealed some blurring of the temporal margins of the disks with slight venous congestion. A one-plus sclerosis and tortuosity of the rotinal vessels was noted The chest expanded equally bilaterally, breath sounds were distant, and numerous wheeses were heard throughout both lung fields There were some medium most rales at the left base. The heart sounds were poor, the rhythm regular, and there was no pulse deficit. The second pul monic sound was accentuated and there were no murmura. The liver was palpable three-finger breadths below the costal margin and there was slight costovertebral angle tenderness bilaterally There were irregular ecchymotic areas over the dorsum of both hands. There was no eyanosis clubbing or peripheral edema

Fluoroscopic examination revealed a mottled infiltration throughout both lung fields with linear streaking toward both apices

Laboratory studies indicated a white cell count of 10 500 with the following differential seg mented forms, 67 per cent stab forms, 11 per cent, eosinophils 1 per cent lymphocytes, 19 per cent, and monocytes, 2 per cent The hemoglobin was 125 Gm, and the platelets, 350 000 Urmalysis showed specific gravity, 1012, albumin, four plus sediment had occa sional red and white blood cells Blood chem istry was nonprotein nitrogen, 33 mg per 100 cc., total protein 50 Gm per cent, albumin 31 globulin, 19 Gm. per cent. Gm per cent Sedimentation rate was 18 mm per hour blood Wassermann reaction was negative. Prothrombin time was normal Electrocardiogram showed sinus tachycardia of 110, left axis deviation, low voltage, occasional premature con tractions, and T waves inverted in leads II and Roentgenogram of the chest revealed ex tensive interstitial changes and fibrous at the roots. Chronic fibrotic infiltrations extending throughout both lungs, especially marked in the lower halves were noted, also a small effusion with thickened pleura at the bases.

Course —A thorncentesis was performed both for diagnostic and therapeutic purposes. Twelve

hundred cc of fluid was obtained from the left It was straw-colored and jelled pleural cavity Smears of the fluid failed to reveal any quickly organisms A culture was reported as Staphylococcus aureus but it was thought to be a con-It was noticed that the fluid reaccumulated rather quickly Two days later a thoracentesis of the right pleural cavity was performed and 300 cc of fluid obtained which showed no organisms on smear He was placed on diuretic therapy with moderate response His general condition, however, failed to improve, and his course continued downhill

Many urnalyses revealed specific gravities ranging from 1 012 to 1 022. Albumin ranged from a trace to four-plus, and there were occasional red and white blood cells and hyaline and white blood cell casts noted at one time or another. Blood counts showed a white cell count ranging from 12,000 to 13,000 with a differential varying little from normal. The hemoglobin level persisted at 11 to 12 Gm. Numerous sputa were all negative for acid-fast organisms. The alkaline phosphatase level was 4.5 Bodansky units, the phosphorus, 4.1 mg. per 100 cc. and 3.01 mg. per 100 cc. on 2 determinations.

Several observers suggested that the clinical symptomatology might be that of a generalized arterial disease and, hence, a muscle biopsy was done. It was reported as "atrophy of striated muscle." Fluid was reaccumulating rapidly and a third thoracentesis was done with results similar to the first two. The patient developed difficulty in voiding and was seen by the urological service. Two strictures of the anterior urethra were noted and a filiform catheter was passed after which profuse bleeding occurred

A repeat electrocardiogram on the tenth day revealed "showers of premature contractions interrupting normal rhythm"

On the twentieth day he had a sudden attack of dyspnea and sharp substernal pain made more severe by coughing. There was no hemoptysis Examination of the chest revealed dullness at both bases with diminished breath sounds and diminished vocal fremitus, wheezing, and prolongation of the expiratory phase Oxygen, aminophylline, and mercupurin provided some degree of relief. On the following day he appeared much improved and an excellent diuresis was obtained. It was thought that the episode had been one of left ventricular failure.

Fluid continued to reaccumulate on the left side and the purpuric-like lesions on the dorsum of the hands became more pronounced. The vitamin C excretion in the urine was 305 mg in twenty-four hours, the normal being at least 50 mg for the same period of time. There

was some calf tenderness but no evidence of thrombophlebitis. He was placed on a high vitamin intake. The purpuric lesions on the hands improved but the patient continued to lose much weight and to have anorexia. Several thoracenteses were done thereafter, and all smears and cultures of the fluid were negative

On the fortieth day he became very dyspneic and orthopneic, developed a more productive cough and was very restless His lungs revealed numerous moist rales, and a pleural friction rub was heard anteriorly to the right of the sternum at the 6 and 7 interspaces In the following two days his cardiac failure became more severe, he had developed auricular fibrillation and there was a friction rub at the left base Fluid again was removed from the left chest, its specific gravity was 1 008 Following thoracenteses, x-rays were described as showing "encysted areas of pneumothorax in the regions of the previous effusion" and "disseminated and confluent nodular productive infiltrations involving the major portion of both lungs " A Congo Red Test showed the four-minute sample to be 100 per cent, the one-hour sample, 90 to 95 per cent, there was no dve in the urine On the fortysixth day the patient expired

### Discussion

DR MAX TRUBEK There was a history of prolonged cough and purulent expectoration since the age of thirteen following bronchopneumonia after measles. We can surmise a widespread bronchiectasis. At no time were tubercle bacilli found in the sputum. The x-ray evidence of old apical fibrosis may represent obsolete disease which did not play any part in his subsequent course.

During this final phase the illness was characterized by progressive emaciation, periodic reappearances of pulmonary infiltrations involving the lower portions of both lung fields, and the reaccumulation of large amounts of pleural fluid which was clear and sterile. There was considerable chest pain at times, pleural in nature and intensified by respiration. Some of the chest pains were angulal in nature and distribution.

A low-grade febrile course with a mild leukocytosis persisted. There was never evidence of severe renal damage. The abnormal sediment may have been due in part to the presence of an old urethral stricture. A muscle biopsy did not confirm an impression of disseminated vascular disease. Electrocardiographic alteration, low voltage in all leads, with inversion of the T wave in leads II and III, lent support to the impression that some of his pain was on the basis of coronary arteriosclerosis and that there

might have been an old myocardial infarction One could not consider many of his chest find ings as due to congestive failure but on the basis of a progressive parenchymal infection of a nontuberulous nature.

Dr. EMANUEL APPELBAUM This case is rather difficult to interpret. There appear to be 2 important factors, namely, cardiac and pul monary The patient obviously had arteriosclerotic heart disease, with or without a provious closure of a coronary artery Whether or not be had in addition a cor pulmonale is difficult to decide on the basis of the information avail able. Unfortunately, venous pressure studies were not made The electrocardiographic find ings however, are consistent with changes occasionally encountered in chronic cor pul monale. With regard to the lungs there is no doubt that the patient had a chronic bronchitis The recurrence of pulmonary episodes with the development of fluid suggests a chronic in flammatory process, possibly of a tuberculous nature The picture is consistent with a diag nosis of chronic miliary tuberculosis of the protracted hematogenous dissemination type.

### Pathology

Dr. Henry Spitz The anatomic diagnoses were acute and chronic bronchitis, fibrosis and emphysema of lungs, bronchiectasis, infected lobular pneumonia, all lobes, organizing pneumonia right middle and lower lobes, chronic adhesive pleuritis with effusion, blateral, chronic adhesive pericarditis with calcification, hypertrophy and dilatation of heart, mainly right ventricle (Cor pulmonale), and sclerosis of coronary arteries.

Autopsy showed a cachectic, middle-aged white man. There was no peripheral edema. An old, healed laparotomy scar was present in the epigastrium and a healing incision was noted over the right calf. There was no free fluid in the abdominal cavity. The provimal loop of the jouinum communicated with a gastric stump by a competent old anastomosis and fibrous ad heatons attached the duodenum to the liver and gallbladder.

Both pleural cavities were for the most part obliterated by dense fibrous adhesions. In the pockets between these adhesions there were 500 ec of clear yellow fluxd on the right and 200 cc. of similar fluid on the left.

The percardial sac was likewise obliterated by fibrous adhesions that contained several large calcified plaques, one of which lay along the left lateral border of the heart.

The heart weighed 360 Gm. which was considered to indicate hypertrophy since all the other viscers were small and atrophic, the liver

e.g., weighed only 890 Gm and the spleen, 40 Gm All chambers of the heart were dilated. The hypertrophy was most marked in the right ventricle that measured 7 mm in thickness as compared with 13 mm for the left ventricle. The valves, save for mild diffuse fibrous, showed no important changes. The coronary arternes were considerably narrowed in many areas by atherosclerotic and calcified plaques, but were not completely occluded. The myocardium was traversed by minute gray streaks of fibrosis, but no gross infarcts were present. In the left auricular appendage a small mural thrombus was found

The intimal surface of the norta was puckered by many atherosclerotic plaques The kidnoys, which were small, weighed together 210 Gm and showed a finely granular surface.

The lungs weighed 650 Gm. each pleural surfaces were covered with torn fibrous adhesions The parenchyma was crepitant in The greater portion of the lungs was few areas subcrepitant or rubbery and on section a grayishred cut surface was revealed, extensively mottled with black All lobes were involved and in areas the cut surface was gray and glassy Foamy fluid exuded on slight pressure Plugs of puru lent exudate projected from the transsected small bronchi and bronchioles The larger bronchi and the trachea contained abundant mucopurulent exudate. The pulmonary arteries showed many small lipoid deposits The tracheobronchial lymph nodes were enlarged soft, and diffusely anthracotic.

The liver was small and markedly congested The gallbladder contained many tetrahedral calculi with rounded edges. Its wall was thickened The bile ducts were grossly unaltered The spleen was small, fibrotic, and congested The adrenals showed considerable cortical hyperplasia The other organs showed no important gross abnormalities The diaphragm, pectoral psoas, and anterior abdominal muscles appeared normal

Microscopic examination showed severe acute and chronic inflammatory reaction in the bronchi and bronchioles The lumins were filled with polymorphonuclear cells and the walls infiltrated with polymorphonuclear cells, lymphocytes and plasma cells. The elastic and muscular elements of the bronchi were disrupted. Adjacent interalveolar septa were thickened by granulation tissue. Many alveoli were distended and con tained varying numbers of red blood cells polyps, and macrophages. In some areas there were numerous heart failure cells." Sections taken from the right middle and lower lobes showed, in addition, extensive replacement of the exudate by granulation tissue filling many alveoli. The bronchioles and unobstructed alveoli were widely

dilated and occasional interalveolar septa were ruptured Many small pulmonary arteries showed intimal thickening Liver and spleen showed marked chronic passive congestion There was mild generalized arteriosclerosis. No other important changes were noted

### Conclusions

This patient apparently suffered from chronic bronchitis of longstanding, with resulting pulmonary fibrosis and emphysema. The sclerosis of the finer pulmonary arteries and the extensive pleural adhesions further added to the strain of the right ventricle, as evidenced by the hypertrophy and dilatation of this heart chamber. The blood supply to the myocardium was certainly limited by the marked sclerosis of the coronary arteries and the patient was probably on the verge of decompensation for quite some

Further decrease of oxygenation by a rather extensive organizing pneumonia and lobular pneumonia in all lobes was probably responsible for the fatal outcome The pericarditis probably did not materially embarrass the heart Concretio cordis produces peripheral and, especially, hepatic congestion only when there is abundant thick dense scar tissue constricting the orifices of the venae cavae and holding the heart in a viselike constriction, thereby impeding the diastolic dilatation of the chambers 1 This was not present in the case under discussion The calcified plaques were so located in the loose fibrous adhesions as not to compress the veins emptying into the auricles

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# SCIENTIFIC EXHIBITS 1948 ANNUAL MEETING

Applications for space for the scientific exhibits should be made directly to Chairman of Subcommittee on Scientific Exhibits of the Convention Committee

Dr J G Fred Hiss 505 State Tower Building Syracuse 2, New York

The Annual Meeting will be held May 17 to 21, 1948, at the Hotel Pennsylvania in New York City

No Applications can be considered after January 15, 1948

There will be two groups of awards

Awards in Group I are made for exhibits of individual investigation, which are judged on the basis of originality and excellence of presentation

Awards in Group II are made for exhibits which do not exemplify purely experimental studies and which are judged on the basis of excellence of presentation and correlation of facts

W P ANDERTON, M D, Secretary

#### CARBON TETRACHLORIDE POISONING

Report of Seven Cases with Two Deaths
IRVING GRAY, MD, FACP Brooklyn, New York

ARBON tetrachloride is one of the most widely used organic solvents by reason of its action as a solvent which is noninflammable It is frequently used as a dry cleaning fluid because it is noncombustible. In industry it is used as a decreaser of metals, as a solvent for rubber, and as a fire extinguishing agent reactions may result from a short exposure to a high concentration of the vapor from prolonged or frequently repeated exposures to moderately high concentrations, or from regular, daily ex posure to low concentrations in excess of known or accepted safe limits 1. The highest concentration of carbon tetrachloride permissible in workrooms is usually given as from 50 to 100 parts per million \*

Toxic effects are produced either by the in halation of the vapor, through skin absorption, or through ingestion. Acute poisoning is usually due to breathing in an atmosphere containing high concentrations of carbon tetrachloride. The results of inhalation experiments on humans were reported by Lehman and Flury 1 In some instances habituation or an increase in tolerance to the effect of carbon tetrachloride has been reported 4 Carbon tetrachloride is a metabolic poison as indicated by numerous experiments on animals and findings in humans.\* The United States Department of Labors in 1941 listed 48 occupations in which there is exposure to the absorption of carbon tetrachloride. Occasionally a delayed fatal type of poisoning, with death occurring one to two weeks after exposure to a single inhalation of high concentration of carbon tetrachloride, may occur Dillingberg and Thompson reported the occurrence of 20 cases of poisoning following the use of the solvent for cleaning the deck and bulkheads without adequate ventilation in a confined compartment of a submarine. Only two men had worked with the solvent and the rest inhaled the fumes over a period of two days because of their proximity to the workers. Death occurred in only one in stance when the patient, apparently on the road to recovery, developed acute pulmonary edema and died Although renal damage was present in eleven patients, there were no evidences of gross liver damage.

The report of these cases of carbon tetra chloride poisoning serves to remind the medical profession of the dangers inherent in chemicals which are widely and at times carelessly used both in industry and among the general population.

#### Nonfatal Cases

Case 1 -F A., a negro man, 41 years of age, worked for a period of eleven years mixing all sorts of chemicals, especially carbon tetrachloride in the manufacture of polishes. In July 1941, he began to complain of blurring of vision Two months later faundice set in associated with nauses, vom iting weakness, and weight loss. Examination approximately two months after the onset of the illness revealed a slight enlargement of the liver with diminution in vision affecting both eyes. The icterus index was increased and the van den Bergh was a delayed positive. There was a slight hypochromic anemia Various liver function tests were within the range of normal. The patient improved following his removal from work. The liver became normal in size, the interus index returned to normal, and the anemia improved following therapy The blood test and spinal Wassermann test were reported as positive Colleidal gold study of the spinal fluid showed a paretic type of curve (555-321-000). Four months prior to the onset of the patient's Illness, examination of the eyes revealed normal findings. During the height of the patient s acute illness there were no abnormalities on examination of the urine and renal function studies were normal

Symptoms referable to the central nervous system are known to have occurred and have been described. Although changes in the optic nerve can occur in individuals with luce of the central nervous system, the onset of sudden manifestations refer able to vision in this individual who developed clinical and laboratory ovidences of acute carbon tetrachloride poisoning was attributed to the in halation of carbon tetrachlorides.

Case 2 -J R. a white man, 44 years of age, was employed as an electrician on ships. He was engaged in cleaning out armatures in the engine room. working with pails of carbon tetrachloride pouring the stuff over the armature. On the second day, the patient complained of names vomiting, diar rhea, weakness, dissinces, and blurring of vision. He was removed from his environment and treated at home and subsequently at the hospital in accordance with the recommendations of Davis and Haneline and Allison. Within several days after exposure, there was a progressive diminution in secretion of urine The patient voided approximately 500 cc. on the fourth day of his illness. Examination of the urine at this time showed a four plus albumin, and on microscopic study there were 10 to 15 white blood cells and an occasional

Presented at the 141st Annual Meeting of the Medical Boriety of the State of New York, Buffalo, Section on Industrial Medicine, May 7 1947

red blood cell per microscopic field. There was a progressive increase in both the systolic and diastolic blood pressure At the end of two weeks the blood urea was 150 mg per cent, the blood creatinine was 7 5 mg per cent and the nonprotein nitrogen, 180 mg per cent On the twelfth day the blood pressure was 190/110 The liver was slightly enlarged but there was no laundice and no increase in the icterus index Convulsive seizures were associated with the laboratory findings as reported above The patient responded to intravenous hypertonic glucose in Hartman's solution to combat acidosis In addition, he received insulin in small doses, two to three units of U-20, four times daily to facilitate metabolism of carbohydrates, proteins, and fats He also received calcium glu-conate intramuscularly The patient was on a high carbohydrate, moderately high protein, and At the end of the second week a few low fat diet granular casts and 2 to 8 red blood cells were noted in each microscopic field on examination of the urine

Approximately seventeen days after exposure. clinical improvement became manifest by decrease in the severity and frequency of the convulsive seizures associated with a gradual drop in the blood urea, nitrogen, and blood creatinine. At the end of the third week, the systolic pressure ranged between 150 and 160, and the diastolic between 90 and 100 At the end of the fourth week, the systolic blood pressure was 130 and the diastolic, 80 The blood creatinine and urea reached normal levels at the fifth week. The icterus index was at no time elevated Approximately seven weeks after the acute onset of symptoms the unne showed normal findings The blood chemistry was normal and the systolic blood pressure ranged between 120 and 130 The diastolic pressure ranged between 78 and 84 The heart size, as determined by teleroentgenographic study, was normal. The electrocardiogram, sedimentation rate, blood count, and all other studies revealed normal findings two months after the onset of the acute poisoning The patient was last examined four months after the renal complications of acute carbon tetrachloride poisoning and, on physical examination and after complete laboratory studies, evidenced no abnormalities It is evident from this case report that the patient had an acute toxic nephrosis due to carbon tetrachloride, in which there was an uncomplicated recovery The clinical and laboratory studies in acute toxic nephrosis due to carbon tetrachloride poisoning were thoroughly described by Corcoran and his co-workers 10

Case 3—J W, a white man, 32 years of age, was employed for several years as a marine electrician In June, 1946, he was cleaning electrical equipment on a tug-boat, using carbon tetrachloride and kerosene, spraying under pressure. Four days after this exposure he began to complain of headache, nausea, dizziness, "felt flushed and tired and became yellow." The patient was removed to a hospital and treated there for a hepato-renal syndrome. The jaundice gradually receded and evidence of touc nephrosis lessened. When the patient was first seen two months after this episode.

he still complained of headaches, dizziness, and weakness He had lost twenty pounds in this period of time He still had a slight anemia (Hemoglobin was 75 per cent or 129 Gm. The red blood count was 3.950,000) The differential blood study was normal except for the presence of 7 eosinophils There was a gradual return of the blood urea, blood creatinine, and the icterus index to normal liver, which was enlarged and felt three finger breadths below the costal arch when the patient was first seen, did not return to normal size for about four months, although liver-function studies were normal two months after the onset of the acute The patient responded to intravenous illness glucose and calcium therapy, and a diet high in carbohydrates and proteins but free from all fats The patient was last seen six months after the acute exposure and all findings on physical examination and laboratory investigation were normal except for a slight secondary anemia. In this instance there were clinical and laboratory evidences of the hepato-renal syndrome due to carbon tetrachloride absorption The patient made an uneventful re-

Case 4 -S L, a white man, 21 years of age, worked for approximately two months using carbon tetrachloride while cleaning machinery. The carbon tetrachloride passes through a rubber hose and "is worked by a pump cleaning the machinery, but quite a bit gets in the air" The machines were cleaned about 4 to 5 times a day, twenty minutes at a time Two months after this type of work, the patient began to complain of nauser, vomiting, "cramps and pain in the stomach," and headaches The essential finding on examination was the slight enlargement of the liver with an icteric tinge of the conjunctiva The icterus index was 14 There were no abnormal findings on examination of the Blood chemistry studies were normal The patient had a slight anemia He was removed from his occupational activity and gradually improved following the use of an adequate diet and intramuscular injections of calcium gluconate, liver extract, and vitamin B Liver function studies and the icterus index were normal within two months after removal from contact with carbon tetrachloride

Case 5 -M L, a white man, 40 years of age, worked for approximately twelve months in a laboratory using carbon tetrachloride to clean metal The patient was accustomed to taking six to eight glasses of beer daily About one year after he began working, "had trouble with my stomach-nausen, vomiting and became joundiced" The patient was hospitalized for a period of two months He was treated for a hepatitis due to carbon tetrachloride poisoning The liver was enlarged about two finger breadths below the costal arch Laboratory investigation revealed evidence of injury to the liver parenchyma. The icterus index gradually dropped from 24 to 10 at the end of two months when the patient was discharged from the hospital There were no renal complications When he was last examined three months after the onset of his illness the edge of the liver was felt on deep inspiration, but all studies including various laboratory procedures for liver function revealed normal findings. (Bromsulfalcin test—less than 10 per cent of the dye recovered in half an hour. Icterus index was 8 the hemoglobin was 88 per cent or 14 96 Gm. The red blood count was 4 500 000, white blood count and differential study were normal Urea, nitrogen, and creatinine revealed normal findings.)

#### Fatal Cases

Case 1 -C M, a white man, 88 years of age, had worked for a period of six years as a "refrigeration mechanic using carbon tetrachloride to degrease various metals.' In the latter part of 1938 the patient developed jaundice and was found to have an enlarged liver and an enlarged spicen Labora tory investigations revealed essentially normal findings except for an increase in the leterus index (16) and a secondary anomia with associated macrocytosis. The patient responded to treatment and within six months after the onset of the hepatitus ascribed to the absorption of carbon tetrachloride there was a normal blood count and the icterus index was normal. The patient continued in his consumption of beer and whiskey and the size of the hver did not recede When examined nine months after the onset of his acute illness, the liver was still felt two finger breadths below the costal arch. The spleen was not felt. The patient stated that I worked for six years with carbon tetra chloride which was kept in open pans and used for degreasing metals. The patient returned to work approximately six months after the onset of his acute illness and was not exposed again to the absorption of carbon tetrachloride. The use of this substance had been discontinued. However it was evident that there were progressive liver changes and the patient developed the clinical syndrome of cirrhesis of the liver There was progressive jaun dies associated with the clinical picture of an atrophic cirrhosis of the liver The patient died about three years after the onset of his first symptoms of hepatic disease After autopsy the follow ing findings were described on examination of the liver

Autopsy Findings —Liver was pale grayish yellow color markedly firm, moderately diminished in size with presence of finely granular surface Beneath the capsule of the anterior surface right lobe were numerous pur point dark blue and recognitive areas. The cut surfaces were translucent and grayish yellow with widely scattered minute, opaque yellow zones. Microscopic.—Dogeneration of the liver cells shown with mild stass (organ not grossly deformed but finely granular) Changes in the liver were those of an old cirrhosis with varicustic of gastric and esophageal volus hyper plastic spleen There was evidence of recent, severe, acute liver damage superimposed upon old pathologic process and subacute yellow strophy

In this instance we are dealing with a known alcoholic addict who was exposed to the absorption of carbon tetrachloride over a period of any years. From a description of his work, the patient had had

repeated contact of the skin with the hourd and absorbed the carbon tetrachloride probably directly through the skin It is stated that alcoholic addicts, obese persons, undernourished individuals, and those ill with diabetes liver or renal disease are likely to be especially susceptible to the effects of absorption of carbon tetrachloride.1 In this case the patient was a known alcoholic addict for many years and when first seen was joundiced and had an enlarged liver The size of the liver did not return to normal. and there is reason to believe that the continuous intake of alcohol over a period of many months and years following the symptoms of carbon tetra chloride intoxication, was probably the cause of the progressive changes in the liver long after all the acute manifestations of carbon tetrachloride poisoning had subsided On the basis of the pathologic report, there were findings in the liver of an old pathologic process with evidence of recent, severe acute liver damage. Although there were clinical findings to indicate that the patient had recovered from his carbon tetrachloride poisoning within several months after he first took ill the question is speculative as to whether or not there were progressive changes in the liver due to carbon tet rachloride following a superimposed effect produced by the daily intake of alcohol for about three years, up to the time of death.

Case 2 - J H. a white man, 33 years of age, was employed as an electrician for a period of about two years. He worked for eight hours 'with a gallon or more of carbon tetrachloride to dry the main propulsion motor which had been submerged The carbon tetrachloride was shot into the motor by means of a fire extinguisher. The work was done in the main engine room below deck. After several hours of exposure to the inhalation of carbon tetra chloride, the patient felt 'woozy began to have nausea vomited, and had pains in the stomach Within forty-eight hours the patient had evidence of both renal and liver damage There were progressive clinical and laboratory findings of hepatic and ronal insufficiency with death occurring ten days after exposure to the inhalation of carbon tetra chloride The essential findings at postmortem examination were as follows There was congestion of the viscers with the liver nutmeg, congestion of the spleen, stomach small intestine and edema of the kidneys.

Microscopic Examination of the Kidneys In general the glomeruli were normal. The glomerul capillaries in most instances were dilated. The afferent arteriols as it entered the glomaruli was extremely dilated. Here and there the cells lining Bowman's capsule were swellen. The tubules for the most part were dilated. At the surface, many tubules were degenerated some completely others partially. Here complete degeneration was observed. The area was occupied by loose connective tissue infilitrated with a very occasional lymphocyte. In the medulla Honk's loops and a few of the ascending and descending tubules were plugged with a coarse cosinophilig granular material resembling a hemoglobin cast. In an occasional tubule also were found free epithelial cells. In still until the coarse of the coarse of the coarse of the coarse of the coarse occasions.

other tubules there was an occasional red cell Scattered here and there were remnants of tubules partially replaced by small basophilic bodies resembling small collections of calcium. In the medulla there was an intense engorgement of capillaries with red cells Arterioles showed no essential Toxic nephrosis intrinsic change  $D_{lagnosis}$ 

Microscopic Examination of the Liver sential pathology was observed in the inner one third of the liver lobules Here the central veins were dilated and engorged with blood cells about the central vein were for the most part completely disintegrated Here and there in these areas there was round cell infiltration sinuses were distended with blood. In an occasional bile capillary a so-called bile thrombus was found Scattered cells contained large clear vacuoles Diagnasis Acute necrosis of the liver

This patient was a known alcoholic addict He had inhaled carbon tetrachloride for a period of eight hours. There was no response to therapy and clinically the patient had evidence of a hepatorenal syndrome due to acute carbon tetrachloride poison-Microscopic examination of the liver showed an acute necrosis and examination of the kidneys revealed evidence of a toxic nephrosis

Exposure to the absorption of carbon tetrachloride and the onset of hepatic disease as manifest by jaundice does not necessarily indicate that the liver disease is due to the absorption of this organic solvent Two years ago, a man, aged 58, who had been working for a period of three years in a cleaning and dyeing establishment, developed naundice and enlargement of the liver In his work, he was exposed to the absorption of various solvents including carbon tetrachloride Upon removal from his work and adequate therapy, there was a period of temporary improvement which led to the assumption that the patient's jaundice was due to a hepatitis of occupational origin After this temporary period of improvement, the patient went progressively downhill The liver became irregularly enlarged and there was marked weight A diagnosis of carcinoma with biliary tract obstruction and metastasis to the liver was made The patient died about eight months after the onset of his first symptoms At postmortem, a carcinoma of the head of the pancreas was found 11 The early and clinical impression when this patient was first seen, that he had a hepatitis due to carbon tetrachloride absorption, was not borne out by subsequent events

In individuals of middle age, the onset of jaundice and hepatic disease may be due to any one of several factors such as carcinoma, silent stone in the common duct, hepatitis of infectious origin, and other causes These conditions should be considered in the differential diagnosis even though the individual is exposed to the absorption of carbon tetrachloride

### Discussion

Dr Marvin L Amdur. Buffalo -The majority of the cases which Dr Gray has presented have occurred as the result of exposure to carbon tetrachloride (CCL) vapor during the course of degreas-Other than its other iming electrical equipment portant application in home or industrial dry cleaning, no other single application is as productive of as much personal exposure It is perhaps fortunate that the usual degreasing operations employ trior perchlorethylene in standard degreasing equip-Were carbon tetrachloride as commonly used, its greater toxicity would make for considerably more trouble Particularly is this so if. as so frequently happens, safety supervision is poor, or the personal operational procedures are bad with resulting too rapid operation, excessive agitation of the solvent, or excessive dragout One would. too. have to contend with mechanical breakdown and improper installation. It is unfortunate that carbon tetrachloride finds its most popular application where supervision in its use is minimal and, apparently, respect for its toxicity is least

Dr Gray has pointed out the incompatibility of alcohol and CCl, and how, in the presence of the former, the toxicity of the latter is enhanced This should emphasize to those of us doing industrial preplacement examinations the necessity of excluding from degreasing operations all alcoholic addicts as well as persons with diabetes and any who present recordable defects of their hepatic or renal systems or in whom a previous history of disease af-

fecting these systems can be obtained

I should like to say a word with respect to the periodic examination of those already employed in degressing operations It is very difficult to antici-The usual laboratory procedures pate trouble are of greater value in confirming an obvious exposure than in aiding in the anticipation of an impending disability I would suggest a good functional inquiry, particularly with respect to weakness, anorexia, and disturbances of sleep and vision, supplemented with a careful examination Dr Gray has illustrated how general medical diseases may mimic, masquerade as or coexist with occupational The differential as always must be whether or not an adequate exposure has occurred we are apt to be confused by the great variability in accepted safe working levels for atmospheric contamination The New York State Department of Industrial Hygiene considers 75 parts per million as a safe working level for an eight-hour day However, we are all aware of how serious illness and even fatalities may follow what quantitatively seems to be a trivial exposure Perhaps there should be some downward revision of permissible concentration to 50 parts per million or even to 30 parts per million

One last point with regard to the treatment of individuals overcome with solvent vapor toxicity of the aliphatic hydrocarbons is greatly increased upon the substitution of the third halogen atom in their structure. Some of this toxicity is directed toward a markedly increased irritability of the heart, particularly in its sensitivity to the

effect of adrenalin. Thus adrenalin given as a stimulant may induce a fatal ventricular fibrilla tion By the same token what I have said about carbon tetrachloride would apply to chloroform (CHCl.) or tribromethanol.

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#### MEETING OF ACADEMY OF DERMATOLOGY AND SYPHILOLOGY

The sixth annual meeting of the American Acad emy of Dermatology and Syphilology will be held in Chicago from Saturday, December 6 through Thursday, December 11 it has been announced by Dr Earl D Osborne secretary-treasurer of the Acad-emy, 471 Delaware Avenue, Buffalo New York The principal sessions will be held at the Palmer

House, with special courses in histopathology and mycology scheduled for Saturday and Sunday, December 6 and 7, at the medical schools of the University of Illinois and Northwestern University Oniversity of minos and vortainesser ourversity of Historic College of Medicine, in Chicago on the after nooms of December 8 0, and 10

Special courses in historathology mycology, x
ray and radium therapy bacteriology of the skin, mucous membrane lesions industrial dermatoses,

specific granulomata and dermatoscleroses will be given by leaders in these various fields.

Subjects to be discussed in symposia will include physiology and chemistry of the skin physical and pharmacoutical therapy cutaneous allergy syphilis pharmacoutical therapeutics, and diagnostic methods in dermatology Other features will be a round table discussion on dermatopathology and a panel

on management of skin diseases. Special lectures will be given on "Afferent and Efferent Nerve Impulses of the Skin by G H Bishop Ph.D. professor of neurophysiology, Washington University, St. Louis, Missouri "Virus Discases of the Skin, by Dr Harvey Blank, University of Ponnsylvania, and 'A Study of the Mechanism of the Urticarial Reaction" by Dr A.C Ivy vice-presi-

dent University of Illinois.

### ANNOUNCEMENT OF VAN METER PRIZE AWARD

The American Association for the Study of Goiter again offers the Van Meter Prize Award of \$300 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The Award will be made at the annual meeting of the Association which will be held in Toronto, Canada, May 6 7, and 8 1948 provid ing essays of sufficient merit are presented

The competing essays may cover either clinical or research investigations should not exceed 3,000 words in length, must be presented in English and a typewritten, double-spaced copy sent to the cor

responding secretary, Dr T C Davison 207 Doctors Building, Atlanta 3 Georgia, not later than February I 1948. The committee who will review the manuscripts is composed of men well qualified to judge the merits of the competing essays.

A place will be reserved on the program of the annual meeting for presentation of the Prize Award Essay by the author if it is possible for him to attend. The essay will be published in the annual Proceed ings of the Association. This will not prevent its further publication however in any journal selected by the author

#### INSTRUCTION FOR GENEVA ACADEMY OF MEDICINE

"Modern Methods in the Prevention and Treat ment of Infectious Diseases" is the subject of the postgraduate locture which will be presented to the Geneva Academy of Medicine by Dr William J Orr on December 18. Dr Orr is professor of pediatrics at the University of Buffalo, School of Medi-cine. The lecture, given by the Medical Society of the State of New York with the cooperation of the New York State Department of Health will take place at 8 30 p.m. at the Seneca Hotel in Geneva-

# **EVALUATION OF PENICILLIN IN TOPICAL THERAPY\***

J Lowry Miller, M D , New York City, Juan J Rodriquez, M D , San Salvador, and Anthony N Domonkos, M D , New York City

(From the Department of Dermatology of the Vanderbilt Clinic and Columbia University, College of Physicians and Surgeons)

IN RECENT years a number of new effective agents against pyogenic infections of the skin have been introduced. Evaluation of the indications and limitations of each substance depends on the carefully controlled work of many investigators.

We have treated 250 patients locally, with ointments containing penicillin, penicillin and sulfadiazine or sulfathiazole, Furacin, sulfur in suspension and, recently, bacitracin. Of this number 173 patients have been sufficiently studied to furnish the basis of this report

Early in our experience we came to the conclusion that application of penicillin on the skin can best be accomplished when it is incorporated in an ointment base The ease of application, the relative stability, the effectiveness, and the certainty of strength of penicillin in ointment bases made the preparation of fresh solutions of penicillin unnecessarv Florey and Jennings found the calcium salt to be nonhygroscopic in contrast to the very hygroscopic sodium salt 1 For this reason outments prepared with the calcium salt This agrees with the conremain more stable clusion of Hallett, Osborne, and Jordan after testing and trial of a number of ointments 2 We used an ointment containing amorphous calcium penicilin in anhydrous petrolatum

### Penicillin Ointments

In order to determine if any significant difference in effectiveness could be demonstrated we used ointments containing 500, 1,000, and 2,000 units of penicillin per gram. A series of cases was also tried on a combination of 1,000 units of penicillin and 10 per cent sulfadiazine or sulfathiazole

Cultures were taken on all cases to isolate the responsible organism and to test its sensitivity to penicillin. The cultures were made in casein digest broth containing rabbits' blood. The sensitivity of the organism to penicillin was determined by the dilution method. Organisms whose growth was inhibited by 0.1 unit of penicillin per cc. or less were classified as sensitive. In

our series all organisms were either sensitive to 0 1 unit per cc or else were resistant to 10 units per cc No attempt was made to test with higher concentrations of penicillin

Patients were instructed to use hot compresses of boric acid for ten minutes or longer, three times a day. Saline compresses were later substituted for the boric acid to avoid possible ill effects from using boric acid, as reported by Watson. The necessity for the removal of crusts in superficial pyodermas is obvious. In our series most of our failures and those requiring long periods to clear could be traced to not removing crusts. Hot compresses remove crusts painlessly and, in children, this usually means the difference between removal of crusts and half-hearted attempts with failure. We have seen numerous examples of irritation produced by soap and water.

Heavy metals, acting as catalytic agents, speed up the oxidation and, thus, the destruction of penicillin Hydrogen peroxide and potassium permanganate also hasten the cadation of penicillin and should not be used as wet compresses before applying penicillin ointment

### Results of Penicillin Ointment

Table 1 shows that of 175 cases of impetigo treated with different strengths of penicillin and with penicillin combined with sulfadiazine or sulfathiazole, 91 were followed adequately was obtained in all but 2 patients, both of whom became sensitized to penicillin The median time of cure was six days for the 500 and 1,000 units of penicillin per gram and five days for the 2,000 units, and the 1,000 units of penicillin plus 10 per cent sulfadiazine or sulfathiazole ence to Table 4 shows that in the cases of impetigo staphylococci were found in pure culture in 74 per cent, streptococci in 105 per cent, and mixed infections in the remainder Seventy-five per cent of the cases with staphylococci in pure culture and all but two of those with streptococci were sensitive to penicillin The sensitivity of the mixed infections was much lower Staphylococcus aureus hemolyticus was the responsible organism in 71 per cent of the cases Staphylococci were tested for pathogenicity with mannitol or coagulase

In ecthyma, of the 14 cases followed, the median time of cure, namely six days, and the percentage of staphylococci in pure culture were the same as

Presented at the 141st Annual Meeting of the Medical Society of the State of New York Buffalo, Section on Dermatology and Syphilology May 8 1947

<sup>\*</sup>The penicilin ointment was supplied by Abbott Laboratories North Chicago, Illinois Furacan by Eaton Laboratories Inc. Norwich New York and the bacitracin ointment by Ben Venue Laboratories, Bedford Ohio

TABLE 1.—Results in Treatment of Primary Superficial Infections of the Sein with Penicillin Continent

	07-4-1	Total Cares Studied	In	Days	Treatment Fallure	Reactions to Medication	
Diagnosis and Medication	Total Cases		Median	Maximum	Minimum	Percentage	Percentage
Impetigo contagiosa							
500 U /Gm. penicillin	20	16	6	13	4	0	0
1,000 U./Gm. penicillin	54	42	6	12	Ì	3	8
2 000 U /Gm. penicillin	54 21 20	16 17	Ă	14	3	ě	ē
Penicillin and sulfonamide	20	17	Ř	-ŏ	3	ñ	Ŏ
T AUTORITY WAS BUTTOUR WITH	-20					•	•
Total	115	91				2*	2*
Eothyma .						_	_
500 U /Gm. penicillin	2	1	.6	_		.0	20 0
1 000 U /Gm. peniellin	9	8	10	10	10	20	20
2,000 U./Gm. penicillin	3	2		7	5	0	0
Penicillin and sulfonamide	7	6	6	10	5	0	0
			_	_	_		
Total	21	14				7*	7*
Folliculitis beard							
500 U./Gm. penicillin	4	4	13 11	_	_	78	50
1 000 U /Om. penicillin	6	4	13	15	12	50	0
2,000 U./Gm. peniellin	Ē	Ē	ii	12	5	20	0
Penicillin and sulfonamide	3	2		15 12 15	7	50	50
			_	==			
Total	21	15				50*	13*
Folliculitis elsawhere							
500 U./Gm. penicillin	3	2	•	11	10	0	0
1,000 U./Gm, penicilin	10	i	10	22	Ğ	13	Ō
2 000 U./Gm. penicillin	- K	- I	-7	10	Ř	ō	Ō
2 000 04 Gill. Pentennu						•	•
Total	18	14				7*	0+

<sup>\*</sup> These figures are the percentages of the total group of paltents studied

for impetigo Mixed cultures were less frequent but, when present, were resistant to penicillin in 100 per cent of the cases

Chineal and bacteriologic differentiation between simple folliculities of the beard and the very resistant cases of sycosis vulgaris is almost impossible. For that reason we have classified all as folliculities. However if the differential diagnosis is made on duration of infection alone 5 of the cases were of more than eight months' duration and 4 of the treatment failures occurred in this group. The fifth treatment failure resulted from sensitiation of the patient to penicillin. As before, the Staph, aureus hemolyticus predominated in both the cases of short and long duration.

In the group of various dermatoses with second ary infection listed in Table 2 pencillin ointment proved of outstanding value in clearing the second ary infection but of no value against the primary dermatosis However sensitization to penicillin was noted in 10 per cent of the patients in this group

The report of Rammelkamp and Keefer sug gesting that experimental studies showed a synergustic action between penicillin and the sulfon amides caused us to try a series on a combination of 1 000 units of penicillin and 10 per cent sulfa diagne or sulfathiaxole <sup>4</sup> The results in 17 cases of impetigo showed a median time of cure of five days in 0 cases of eethyma, a median time of cure of six days. No evidence of sensitization of the patients was noted.

The objection is often raised to the use of the sulfonamides and penucillin locally because of the inherent danger of sensitization of the patient, thus preventing their use parenterally in a serious illness. To offset this objection we were prompted to use Furacin (5-nitro, 2-furaldehyde semicarbazone) which is not intended for systemic use. Dodd and Stillman demonstrated Furacin to be

TABLE 2 —RESULTS IN TREATMENT OF DERMATORES WITH SECONDARY INFECTION WITH PERICILLIN CHATMENT

Diagnosis and Medication	Total Cases	Total Cates Studied	In	lecti n Contr	Treatment Failure.	Reactions to Madication Percentage	
			Median	Maximum	Minimum	Percentage	
Allergic ecsema 500 U./Gm penicillin 1,000 U./Gm. penicillin 2,000 U./Gm. penicillin	2 2 1	1 1	8	8	3	0 0 0	0 0 0
Total	5	4				0	0
Seborrheie dermatitis 1 000 U /Gm penicillin Contact dermatitis	2	1				100	100
1 000 U./Gm. penicillin	2	2	1			50	0
Infectious eczematold dermatitia 1 000 U./Gm penicillin	1	1	5			0	0
Abrasion 1 000 U /Gm. penicillin	1	1	5			0	0
Neurodermatitis 1 000 U./Gm. penicillin	1	1	6			0	0
Total secondary infections	12	10				20	10

<sup>\*</sup> Percentage of t tal cases studied.

TABLE 3—Results in Treatment of Primary Superficial Infections of the Skin and Debnatobes with Secondary Infection with Furacin

Diagnosis	Total	Total Cases	I	Days —	Treatment Failure,	Reactions to Medication.	
	Cases	Studied	Median	Maximum	Minimum	Percentage	Percentage
Impetigo contagiosa Ecthyma	18 2	16 2	8 11	23	8	7 50	0
Folliculitis beard	6	4	12	26	12	50 25	25
Folliculitie elsewhere	5	4	10	17	7	0	0
Aone varioliformia	1	1	8			0	0
Pustular bacterid Secondary infections in	1	1				100	0
Ulcus cruris	6	5	7	18	4	0	20
Contact dermatitie	5	4	19	24	18	0	0
Allergio ecsema	2	2		29	24	0	0
Total	46	39				3*	5*

<sup>\*</sup> Percentage of total cases atudied

both bacteriostatic and bacteriocidal for a number of gram-positive and gram-negative pathogenic bacteria. Dodd, Hartman, and Ward found the material nonirritating upon local application and no evidence of toxicity after prolonged application. Downing, Hanson, and Lamb, Snyder, Kiehn, and Christopherson; Shipley and Dodd, and others have reported on its local use in humans

Exactly the same procedure as in the penicillin series was carried out. Bacteria sensitive to dilutions of Furacin of 1 to 10,000 or higher were classified as sensitive.

### Results of Furacin

In Table 3 the results of using Furacin in 46 patients are recorded. Two patients, or 5 per cent, developed sensitization evidenced by a vesicular dermatitis adjacent to the areas under treatment. Of the 18 cases of impetigo treated, 16 were followed adequately with a median time of cure of eight days. The decided increase in mixed cultures probably should be discounted due to a change of technical assistants. The results in clearing the secondary infections in hypostatic ulders (Ulcus cruris) of the lower extremities in a median time of seven days were encouraging

A small series of cases has been tried on sulfur in suspension. Weld and Gunther have reported a method of preparation of sulfur in Carbowax and given results showing inhibition of growth of many gram-positive cocci when using dilutions as high as 1 to 500 to 1 to 2,000. The preparation seems to be of particular value in treating seborrheic dermatitis.

A similar small series has been tried on bacitracin Bacitracin is a new antibiotic, the discovery of which was reported by Johnson, Anker, and Meleney <sup>11</sup> In a subsequent report Meleney and Johnson<sup>12</sup> found that of 100 patients with a variety of surgical infections as boils, abscesses, infected cysts, and the like, 31 per cent showed excellent results when bacitracin was used either locally or injected into the lesion Fifty-seven per cent showed good results We have treated only a few cases with bactracin with adequate follow-up. We have used 500 units of bacitracin per gram in a base of Carbowax and propylene glycol. Obviously, no conclusions are justified but our impression is that it is effective in treatment of superficial pyogenic infections.

### Comment

Most observers are agreed that penicillin ointment is a very effective agent in the treatment of superficial pyogenic infections. In three days Wright and Gross cured 21 of 25 patients with impetigo, when using 1,000 units of penicillin per gram 12 Cohen and Pfaff reported very satisfactory results in the treatment of impetigo 14 Our results with 91 cases of impetigo cured in a median time of six days confirm this opinion. One of us (J L M) found that sulfathiazole or sulfadiazine cured 45 patients with impetigo in a median time of six days 14 From these findings we conclude that penicillin or the sulfonamides are 'equally good and to date unsurpassed from the standpoint of rapidity of cure in superficial pyogenic infections

Ecthyma yields in a manner similar to that in impetigo, usually a little slower, although in this series the results were as quick

In folliculitis the results are very variable Cooke reported clearing 14 cases of uncomplicated sycosis vulgaris with a spray of penicillin filtrate <sup>16</sup> In our cases simple folliculitis yielded rather quickly but true sycosis vulgaris was usually resistant, 4 out of 5 cases being failures

The addition of the sulfonamides to the pencillin ointment produced no dramatic change in the rapidity of clearing of the lesions. Most dermatologists do not approve of the use of sulfonamide ointments locally because of the known danger of serious reactions from sensitization. This danger of sensitization to the sulfonamides, particularly in the absence of dramatic response in the rapidity of cure, rules out the combined use

In the matter of concentration of penicillin we

TABLE 4 -- BACTERIOLOGIC STUDIES

Diagnosis and Medication	Culture,	taphylococci Bensitive Percentage	Resistant	Streptococcus Culture Percentage	Culture Percentage	— Mized — Bensitization Percentage	Resistance Percentage
Impetigo contagiosa				a circuitage			
500 U /Gm. penicillin	75	7.5	25	7	18	•	100
1,000 U /Gm, penicilin	76	59	40	:	is	03	37
1,000 U /Gm, pencina	10	91	41	.2	18	67	
2,000 U./Gm penicillin	70 75	67	- 2	12	18		.83
Penicillin and sulfonamide	19	01	33 27	18		.0 .	100
Total*	74	73	27	10 5	15 5	82 5	67 5
Eethyma			_	_	_	_	
500 U./Qm, penicillin	100	100	0	.0	ū	Ŏ	Ů.
1 000 U /Gm penicillin	80	0	100	20	ū	Ü	<u>o</u>
2.000 U /Gm penicillin	50	100	0	60 17	0	0	0
Peulcillin and sulfonamide	66	50	50	17	17	0	100
Total*	74	62 5	37 5	22	4	0	100
Follicultus beard							
500 U./Qm. penicillin	100	0	100	0	0	0	0
1 000 U /Gm penicillin	100	67	23	0	0	0	0
2 000 U /Om penicilin	80	75	25	20	0	0	0
Penicillin and sulfonamide	100	100	0	0	0	0	0
Total	95	50 S	39 5	5	0	0	0
Folliculitia elsewbere							
500 U /Gm penicillin	0	0	0	100	0	0	0
1,000 U /Gm. penicillin	75	80	80	13	13	0	100
2,000 U./Gm. penicillin	80	Ó	100	50	0	0	0
Total*	41	25	75	55	4	Ò	100

<sup>\*</sup> Percentage of staphylococci and streptococci in total number of cases.

found little difference in results whether we used 500, 1 000 or 2 000 units per gram of ointment

Cormia and Alsever reported achieving satisfactory results when dealing with resistant (above 0 units of penicillin per cc.) staphylococci by in creasing the strength of the ountment to 5,000 to 100,000 units per gram. In Hopkins and Lawrence found this true in similar cases but state that sensitization of the patient to penicillin occurred more frequently. Because of this danger of sensitization by larger doses and because of the satisfactory results obtained with 500 units of penicillin per gram we feel this to be the ideal strength.

Since penicillin ointment has proved a very effective agent in the treatment of superficial pyogenic infections in the experience of many workers, the only objection to its use is the factor of sensitization of the patient. This factor of sensitization from local therapy is of importance from two standpoints first the percentage and the degree of the resulting contact dermatitis and, second the probability of occurrence of this reaction from internal administration preventing the use of penicillin in a senious illness. Penicillin

was early shown to be capable of causing contact dermatitis in persons handling the drug. Fried laender, Watrous and Feinberg report 5 cases of this type and review earlier reports by several observers. This is borne out by Gottschalk and Welss who found that of 7 patients who had prolonged contact with ponicillin 7 reacted to a patch test of penicillin outment. In our series the percentage of sensitiation was low 2 per cent in impetigo. This agrees with other observers who were dealing with patients who had come in contact with penicillin little if at all, and in whom the period of use was relatively short.

In folliculitis our percentage of sensitization increased probably because two patients had used penicilin previously. On the other hand evidence is accumulating that, with the use of penicillin in many forms as lozenges, nose sprnys, and even patch tests alone, the percentage of patients developing sensitization is rising. Pillsbury, 12 quoting Hopkins and Lawrence, and Wrong suggests 10 to 11 per cent to be more nearly the correct figure and that penicillin in-oil given intra muscularly be substituted as less likely, to cause epidermal sensitization.

TABLE 5 -BACTERIOLOGIC STUDIES

	R	taphylococou	,	Streptococous	- Mixed -		
Diagnosis and Medication	_Culture	Beneltive Percentage	Resistant	Culture Percentage	Culture Percentage	Sensitisation Percentage	Resistance, Percentage
Allergic eczema 500 U /Gm. penicillin	••		•	*0	•	^	
1 000 U./Gm. penicilla	.50	100	100	80	ž	Ķ	ň
2 000 U /Gm. peniellin	100	Ä	100	100	Ä	ň	ň
Seborrheie dermatitia	0	U	v	100	v	•	•
1 000 U./Om pentefffin	100	n	100	0	0	0	0
Cont et dermatith	***	•					
1 000 U /Gm. penicillia	80	100	0	0	50	100	0
Infectious eczamatold dern	18-						
titia		_			0	0	
1,000 U /Gm. penicillin Abrasion	100	0	100	0	U	U	
1,000 U./Gm. penicilin	0	0	0		100	0	100
Neurodermatitis	·	·	U	·		•	
1 000 U./Gm. penicillia	100	0	100	0	0	O	0

TABLE 6 -BACTERIOLOGIC STUDIES

		taphylococcu	IR	Streptococcus	Mixed			
Diagnosis and Medication	Culture,	Sensitive, Percentage	Resistant,	Culture, Percentage		Sensitization, Percentage	Resistance Percentage	
Furacin								
Impetigo contagiosa	18	100	0	18	64	84	16	
Ecthyma	0	0	0	50	50	100	0	
Folliculitis beard	33	100	Ö	0	67	50	50	
Acne varioliformis	100	100	Ó	0	0	0	0	
Pustular bacterid	Ŏ	0	Ö	100	0	Ó	0	
Secondary infection in								
Contact dermatitis	50	50	50	0	50	50	50	
Allergio eczema	0	0	0	0	100	50	50	

Several observers have reported instances in which intramuscular use of penicillin has apparently sensitized the patients causing a contact dermatitis reaction. The evidence is meager for the reverse. Most observers are agreed that to date the reactions have been unusually mild, frequently transient, and seldom interfering with treatment. Mahoney has not been forced to treatment with penicillin in a single case in over 5,000 patients because of reactions <sup>22</sup> Cannon reports the same in 1,000 cases <sup>23</sup>

Many dermatologists feel that penicillin like the sulfonamides should not be used locally. We feel that, considering all the evidence to date, this view is too extreme and that its use locally is justified in a strength of 500 units per gram for a short period. The use in previously eczematized areas is open to question and for long periods it is to be condemned.

Furacin offers an agent in which parenteral use need not be considered. Sensitization is a factor here, also resulting in contact dermatitis. We found a 5 per cent incidence in our series. Downing, Hanson, and Lamb found less than 1 per cent in one series of 147 cases and over 10 per cent in another series of 63 patients with a different lot of Furacin. Here again the eczematized patient is the one more likely to react. In our series the number of cases of impetigo is too small for accurate comparison and it is only our impression that the median time of cure of impetigo of eight days as compared with six days with penicillin may be of significance.

Our experience with sulfur in suspension and bacitracin is, as yet, too limited to be of value But the results so far point to a value for sulfur in suspension particularly in seborrheic dermatitis Bacitracin has given some excellent results in the same type of case which yields to penicillin, and has resulted in failure in the type in which penicillin fails

## Conclusions

- 1 Penicillin ointment is very effective in the treatment of impetigo and ecthyma
- 2 Penicillin ointment is of value in simple folliculitis, of little value in true sycosis vulgaris
  - 3 Five hundred units of penicillin per gram

is adequate concentration and is not as liable to cause sensitization as higher concentrations

- 4 Combinations of penicillin and the sulfonamides in ointments should not be employed
- 5 Sensitization of the patient resulting in a contact dermatitis occurs in 2 to 13 per cent of cases, increasing on prolonged contact, repeated exposure, and previous eczematization of the skin
- 6 Epithelial sensitization from local application of penicillin precluding the use of penicillin for serious illness is rare
- 7 Furacin is effective in the same diseases as penicillin ointment. It, too, produces sensitization resulting in contact dermatitis, 5 per cent in this series. Furacin has an advantage in that internal use is not intended.

371 PARK AVENUE

### Discussion

Dr Joseph J Hallett, Rochester, New York —I am in full accord with the conclusions of Dr Miller's paper

Pencillin ointment is most efficient in the treatment of pyodermas such as impetigo, ecthyma, and superficial folliculitis The results of pencillin ountment in sycosis vulgaris have been very disappointing in my experience, even when the strength of the ountment is increased to 100,000 units per gram of ointment Penicillin ointment is of value in treating infectious eczematoid dermatitis, especially those of the external ear following a chronic discharging ear It also has proved of value in treating some cases of chronic postauricular dermatitis of longstanding, especially when there is marked fissuring behind the ear These probably are due to seborrhea, with a superimposed staphylococcus

I do not believe penicillin and the sulfonamides should be incorporated in an ointment for topical use. There is no clinical evidence that the suggested synergistic effect is sufficient to warrant their combination.

The increased probability of cutaneous sensitization to sulfonamides far outweighs their clinical advantage, if any While penicillin does cause some cutaneous sensitization, it is about 7 per cent, the sensitization to sulfonamides is twice this. The usual cutaneous reaction to penicillin is a dermatitis venenata. This may occur as early as the

fifth or sixth day of treatment. It is difficult to ex plain this early consitization. The only suggestion I have to offer is that penicullin, when used topically is always applied on an inflamed or eroded skin, and under such circumstances the epidermal cells may more rapidly become sensitized. I have seen one localized urticarial reaction to the local use of penicillin, and here again it was applied to an ulcer I have never observed, as yet, any vesicular reaction of the toes, fingers or groin following the use of penicillin locally on some other area of the body I have seen this type of reaction following only intramuscular administration of penicillin.

It is my usual procedure in using penicillin oint ment to have the patient return in five or six days, at which time, if there is not marked improvement. I discontinue penicillin ointment and prescribe Furacin or some other cintment. By this means, I believe I have been able to reduce the number of reactions to penicillin ointment.

Furacin is rapidly gaining in popularity as an ef fective treatment in superficial pyogenic infection Here again one must always remember that consiti zation does occur but it is my impression that the percentage of sensitization is low

I have had no experience with the sulfur suspen sion or bacitracia.

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#### A.M.A. HEAD URGES CAMPAIGN AGAINST VASCULAR DEGENERATION

In a paper delivered before the annual meeting of the Kentucky State Medical Association in Louisville, Kentucky, September 30 Edward L Borts
M.D of Philadelphia, president of the American
Medical Association, called degeneration of the blood vessels 'the number one challenge facing the medical

profession today'
'Organized drives in support of cancer research,
the control of pollomyelitis rheumatic fever tuberculosis, and more recently diabetes, have been gen-be given to the challenge represented by the larger numbers of preventable fatalities, the result of a breakdown somewhere in the vascular system.

In my opinion the problem of vascular degener ation is the number one challenge facing the medical profession today Is there a common denominator underlying all of these conditions or does each one arise from causes peculiar to special situations? What variation is there in the pathology in the tissue preduposition, in the quality of the blood of individuals showing these conditions? Does heredity play a part? What influences do the stresses and strains

of modern existence play?

He added The time is at hand when the profession should do something about coronary disease before the final dramatic episode takes place. The

presence of advanced sclerosis might have been identified during careful physical examination with routine electrocardiographic studies. Individuals with hypertension and those addicted to overindulgonce may be classified as candidates for coronary accidents.

In preventing the deterioration of the blood vessels which brings about such accidents, Dr Bortz sug gested that proper diet may be a major factor said that the rodine compounds may be helpful, too

It has been suggested that the very low incidence of atherosclarosis in the population of Icoland is likely due to the common occurrence of iodine in the soil and food he stated On the other hand he observed, an overabundance of cholesterol in the dlet or even the moderate use of tobacco or alcohol may have bad effects on susceptible persons.

Probably the most important protective policy in maintaining an adequate vascular function is therapeutic rest. Dr Borts went on. Especially is this important in individuals suffering from hyper tension. The practice of a mid-day rest period one and one-half to two hours, with the person reclining and removed from bells and other annoyances of all kinds breaks the sustained drive of the daily routine More and more business concerns are making it possible for executives to divide the work day into two portions.

# RAGWEED DERMATITIS (ORAL DESENSITIZATION)

Benjamin J Slater, M.D., John L. Norris, M.D., and Nathan Francis, M.D., Rochester (From the Medical Department of Easiman Kodal Company, Kodak Park)

LTHOUGH ragweed is the most common A cause of hay fever in the United States, it rarely causes dermatitis like that seen after exposure to poison ivy, oak, or sumac The eruption is usually distributed on the exposed surfaces of the body, such as the face, neck, forearms, hands, legs, and feet, and may become general-The condition is not hereditary rule, those who get dermatitis from ragweed do not get hav fever or asthma

The first case reported appeared in 1918, and ten years later it was established that the ether extract fraction from the leaves and the pollen was responsible for the dermatitis, and that the patch test was the only way by which the diagnosis could be confirmed \*

The important factor in the diagnosis is its seasonal incidence and recurrence Symptoms usually appear in August and end with the frost. corresponding with the period of pollination of ragweed However, symptoms may appear as early as May, when the ragweed plant begins to grow, and may continue well up to November, as the ragweed plant maintains its vitality up to that Contact with the withering weed is possible until it is rotted by the snow Ragweed seed in the ground, if handled, may cause symptoms all winter

Symptoms may be present at other times, such as while hunting, weeding, gardening, or while handling hay or grain The symptoms may also be continued by pyrethrum, turpentine, vegetable oils, and industrial sensitizers

# Case Reports

Case 1 —L W, age 40, began to have dermatitis in August, 1940, when he was working as a gardener Eruption was generalized as far as he can remember and lasted all year He has had similar episodes each year since, which come about the same time of the year, starting in May and lasting until after the first of the year He is usually free from symptoms from January to May of each year

His family as well as personal history is negative for allergy Ragweed does not cause hay fever or

asthma in this patient

Turpentine fumes make it worse, as well as rainy weather A patch test with ragweed oil was mark-

Presented at the 141st Annual Meeting of the Medical Society of the State of New York Buffalo, Section on Indus trial Medicine May 8 1947

\*Slater B J Norms J L and Francis, Nathan Occup
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edly positive. It was removed two hours after application because of intense itching

This patient took ragweed elegresin orally in 1946 His skin was normal that year

Case 2 -L B. age 53, was well until late summer of 1938 when he developed eczema of hands, scrotum, legs, and face He was seen by a dormatologist who found him very sensitive to ragweed, goldenrod, and metallic silver The condition cleared in the early winter, but recurred in October, 1939, clearing considerably in mid-November, but not to a degree permitting normal living It became much worse in October of 1940, and at this time, because of its persistence throughout the preceding year, it was thought that he might be sensitive to some of the chemicals with which he was working There was a positive patch test to one of these On November 1. 1943, there was a very severe flare-up of dermatitis following a hunting trip and a garden clean-up, where he had handled tomato vines In January, 1944, he reported that merely to be in the workroom caused his face, neck, and arms to burn, smart, and itch

He had been taking oral ragweed antigen for some months, but he didn't want to continue this as he would frequently get an acute flare-up of trouble if the dosage was not exactly right. His work was shifted to another area where the material used involved only dry gelatine, but even here the eruption persisted He was shifted again to a water purity control job where the only possible exposure was to small quantities of chlorine, but on September 13, 1945, there was the most acute exacerbation ever He was urged to go to the mountains where he improved very promptly and was nearly well when he returned home a month later The condition flared up promptly again so that hospitalization was neces-He returned to work December 10, 1945, still with considerable chronic eczema

### Discussion

These cases are of interest because they show the importance of recognizing ragweed dermatitis when it occurs in industry, as this type of dermatitis is not usually compensible In the first case (L W) the seasonal incidence and recurrence of the dermatitis corresponds with growth and pollination of ragweed, and the diagnosis is substantiated by a positive patch test to the eleoresin of In the second case (L B) it appears that ragweed is the primary cause of the dermatitis, with continuation of symptoms best explained by other factors, some of which may be connected with exposure to industrial sensitizers

#### Treatment

At present, the best advice to give a patient who is afflicted with ragweed dermatitis is to recommend that he go to a place where ragwood does not grow If this is not possible, because of low finances or other considerations, the treatment of choice is by oral description, using the ragweed oleoresin in corn oil. According to

Rudolf Baer, an assistant editor of the Year Book of Dermatology and Syphilology, this may be a safe and effective method of desensitization for rag weed, as well as it has been shown to be an ef fective method in some cases of poison ivy dermatitis. However, one must always be on the alert for flare-ups due to intolerance of the ragweed eleoresin, which may produce an acute execorbation of all the symptoms

#### THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS INC

The following resolution was adopted by the board of directors of the American Society of An esthesiologists Inc., on June 11 1947 in Atlantic

City, N J
Whereas, the development and furtherance of

WHEREAS anesthesiology is a component part of the practice of medicine

Now therefore be it resolved

That the American Society of Anesthesiologists

Inc. recommends strongly

The establishment of departments of anes theslology in all medical schools and hospitals under the direction of a doctor of medicine ac-

tively engaged in the practice of anesthesiology B That the department of anesthesiology shall bear the same relationship to the medical

school and/or hospital as is borne by other medical departments of the institution.

And it be further resolved That the American Society of Anesthesiologists

Inc., disapproves

A. Of the training of persons other than doctors of medicino in the science and art of an esthesia for the assumption of responsibility in the care of patients where it may be necessary to exercise medical judgment, and particularly does it disapprove of the issuance of cortificates for

such training by its members.

B The existence of departments of anesthesial ogy in hospitals and/or medical schools under the direction of persons other than doctors of medi cine or under the nominal direction of doctors of medicine not actively engaged in the practice of anesthesiology

#### ADDED INFECTIONS IN BURNS

Dr L. Colebrook and his associates, writing in the March 15 1947 Lancet London, say that during a twelve months' period involving more than 1 400 dressings, cross infection by hemolytic streptococci Pseudomonas aeruginosa and Proteus vulgaris introduced while dressing burns has been almost entirely eliminated by doing the dressings in a dustfree atmosphere using a strict aseptic technic and using a penicillin-sulfathiasole cream as a routine application

During the same period a few added infections by these three organisms have occurred (33 in all), but most of these added infections oc-curred in patients whose burns had been imperfectly covered before they were redressed. The incidence of added infection in burns which were found to be imperfectly covered when they arrived for redressing was ten times as high (8.6 per cent) as that of the burns which had porfect cover throughout the poriod between dressings (0.8 per cent.) Among the 224 patients admitted without streptococcie infection, only 12 acquired this infection during their stay in the hospital and the clinical effect of these few added infections was practically nil. The problem of controlling added infections of burns with Staphylococcus aureus remains untouched. These infections which are numerous, may well play a prominent part in the slow healing of burns during the later stages of recovery —J A M A July 5 1947

#### COURSES OFFERED TO GENERAL PRACTITIONERS

Columbia University, College of Physicians and Surgeons, New York City, announces the following courses for general practitioners November 3 to 8, at the Roosevelt Hospital "Recent Advances in Allergy", December 15 to 20, at Mount Sinai Hospital, "Recent Advances in Gynecology", December 8 to 12, at Mount Sinai

Hospital 'Recent Advances in Neurology and

Paychintry

November 10 to 20 at Mount Sinai Hospital, Endocrinological Diseases December 1 to 6 at Mount Sinal "Venoreal and Skin Diseases, and December 1 to 23, at Mount Smai, Physi-ology of the Digestive Tract

# House of Delegates

# Minutes of the Annual Meeting

May 5 to 7, 1947

[Continued from page 2216, October 15 issue]

Sections 106-147 (Conclusion) appear in this issue For Subject Index, see August 15 issue, page 1799]

Afternoon Session Tuesday, May 6, 1947

Section 106 (See 55)

Report of Reference Committee on Report of Council—Part VII Medical Indemnity Plan (Genesee Valley Medical Care, Inc )

Dr. Denver M Vickers, Washington There are two resolutions that have been referred to your Reference Committee on which I should like to re-

Dr Leo F Simpson, of Monroe, introduced a resolution requesting the House of Delegates to endorse the Genesee Valley Medical Care, Inc., of Rochester, New York Your Reference Committee approves of this resolution and moves its adoption

The motion was seconded, and as there was no discussion, it was put to a vote, and was unanimously carned

Section 107 (See 56)

Report of Reference Committee on Report of Council—Part VII Medical Indemnity Plan (Central New York Medical Plan, Inc.)

DR DENVER M VICKERS, Washington Dr Leo E Gibson, of Onondaga, introduced a resolution requesting the House of Delegates to endorse the Central New York Medical Plan, Inc., of Syracuse, New York Your Reference Committee approves of this resolution, and moves its adoption

The motion was seconded, and as there was no discussion, it was put to a vote, and was unanimously carried

Section 108 (See 12)

Report of Reference Committee on Report of Council-Part VI Public Relations and Economics, Public Medical Care, Women Medical Students and Interns, Medical Service and Public Relations

DR EDWARD P FLOOD, Bronz Your committee has carefully studied the Report of the Council Committee on Public Relations and Economics and of its Subcommittee on Public Medical Care It commends the Subcommittee upon having secured a revision of the schedule of reimbursable charges of the State Department of Public Welfare, and it approves the two stipulations of the Council in granting its approval to these changes. First, that the schedule does not represent the full value of the medical services given, and second, that the difference between this schedule and the full value represents each physician's contribution to the needy persons

It is with regret, however, that the need for a charitable contribution by the physicians is still deemed necessary in these days of unprecedented prosperity When the TERRA was set up fifteen years ago, it was in a time of severe economic depression, and the medical needs of the large army of indigents could only be met by a sacrifice, on the part

of the medical profession, of its financial interest We hope that, when the present schedule is revised at the end of the year, consideration will be given to the fact that the physician should receive fees which are standard for similar services to the nonindigent The Reference Committee hopes that the preparation and publication of the new Manual of Medical Care will soon be completed

Your Committee has read the report of the Council Committee on Medical Service and Public Relations and noted that representatives of the Committee attend the meetings that deal with the topics of medical expense, indemnity insurance and medical care plans, the Murray-Wagner-Dingell Bill and the Hill-Burton Law, "home town" medical service for veterans, and proposed medical service for bituminous coal miners

The Reference Committee has studied the Report of the Joint Committee of the New York Hospital Association and the Medical Society of the State of New York, and hopes that this Committee will continue its activities in formulating mutually acceptable legislation

It is noted in studying the Report of the Council, Part VI, that no report was made by the Committee on Women Medical Students and Interns, but we note that the Planning Committee for Medical Policies has recommended that this Committee, which was set up at the time of the war emergency, be discontinued, and its functions transferred to the Committee on Public Health and Education

I move the adoption of this report

The motion was seconded, and as there was no discussion, it was put to a vote, and was unanimously carried

Section 109 (See 36)

Report of Reference Committee on Report of Council-Part VI Furnishing of Medical Service with Hospitalization Insurance

DR EDWARD P FLOOD, Bronx Your Committee has carefully considered the following resolution submitted to it as a Reference Committee and submitted by Dr Sol Axelrad, of Queens

"Whereas, the services of the pathologist, roentgenologist, anesthesiologist, and physical therapist are medical services, and

"Whereas, Blue Cross plans wrongfully offer these services to the public as benefits under hos-

pitalization insurance policies, and "Whereas, Associated Hospital Service, the Blue Cross Plan covering seventeen lower New York State counties, has refused to agree to dis-

continue this practice, therefore, be it "Resolved, that the Medical Society of the State of New York, through its House of Delegates, reaffirm its disapproval of such practice, and be it further

' Resolved, that the Society withdraw its en dersement of Associated Hospital Service or other Blue Cross Plan operating in New York State un less the practice of supplying medical service under hospitalization policies is discontinued

This resolution has been amended by the Refer ence Committee as follows

WHEREAS, the services of the pathologist roentgenologist, anesthesiologist and physical

therapist are medical services, and WHEREAS, Blue Cross plans wrongfully offer these services to the public as benefits under

hospitalization insurance policies and
WHEREAR, Associated Hospital Service, the
Blue Cross Plan covering seventeen lower New York State counties, has falled to discontinue this practice, therefore be it

'Resolved, that the Medical Society of the State of New York, through its House of Delegates, reaffirm its disapproval of this practice and there-

fore be it further

Resolved that this House of Delegates memorialize our representatives on the Board of Trustees of the Associated Hospital Service the United Medical Service and other approved medical service plans, to transfer the provision of these specialists' services to approved medical service plans. In furtherance of the alm of this resolution your Reference Committee introduces the following supplementary resolution

Subject Memorializing Local County Medical Societies to Disseminate Information con-

earning Violation of Approved Medical Service Policies in Their Own Communities.

"WHEREAS, certain evils are acknowledged to exist and correction theroof is recognized to be

nocessary therefore be it

"Resolved that this House of Delegates memorialize each County Medical Society to ad vise the Medical Boards and individual mem bers thereof of the importance of establishing in their hospitals the principle that the practice of pathology roentgenology, anesthesiology and physical therapy is the practice of medicine and not a hospital service and that they further request the Board of Trustees of their institutions to discontinue the inclusion of these medical services in any contract for hospital

I move the approval of this report and its substitute resolution.

The motion was seconded and as there was no discussion, it was put to a vote, and was unani mously carried

Section 110 (Sec 50)

Report of Reference Committee on Report of Council-Part VI: Care of the Chronically III

DR. EDWARD P FLOOD Bronz Your Reference Committee considered the resolution introduced by Dr Edwin L. Harmon of Westchester County sublect, 'Care of the Chronically Ill'

Whereas, statistics show that we have an aging population and therefore that the problems of gernatries must receive greater consideration in future planning and

Wheneas, studies have indicated that standards of care for the chronically ill in private nursing homes, now caring for many of the aged, are inadequate and for the most part very coetly and WHEREAS, the Governor's State Health Pre-

paredness Commission has recognized this need and has recommended the establishment of several small teaching hospitals for the treatment of the chronically ill, to be scattered throughout the State, and

WHEREAS, these hospitals cannot meet the present need but will serve as demonstration

projects now, therefore, be it "Resolved, that the Medical Society of the State of New York should interpret this need to the physicians and the public and should urge that the construction of separate buildings or special wings for the care of the chronically ill be included in the building programs of voluntary and public general hospitals throughout the State

The Reference Committee approves this resolu-tion and recommends that, until such projects can be consummated, efforts should be made for the re-habilitation of such of these patients as are indigents in their own homes by the provision of adequate medical, nursing and housekeeping care by public welfare agencies

I vote the approval of this report.

The motion was seconded and as there was no discussion it was put to a vote, and was unani mounly carried

Section 111 (Sec 24)

Report of Reference Committee on Report of Council—Part VI Practitioner in the Practice of Medicine

DR. EDWARD P FLOOD Bronz Your Reference Committee considered the resolution introduced by Dr Benjamin M Bernstein of Kings County, subject. 'General Practitioner in the Practice of Medi

"Whereas, the family doctor is the corner stone in the practice of medicine and

"Whennas, it is most urgent that the rightful place of the family doctor in the present and

luture scheme of modical service be retained and WHEREAS, the development and growth of pecialty boards are inimical to the best interests of the family doctor for whom no provision of certifi

ention or similar recognition is being made and WHEREAS, the acclaim given to the certified specialist in the hospital is rapidly tending to oust the family doctor from any position on a hospital

staff, and
WHEREAS, consideration being given to the establishment of group clinics likewise tends to the demoralization of the family doctor and

'WHEREAS, the incentive accorded the certified specialists for intensive preparation for certifica-tion and continued study is being neglected for the family doctor and

WHEREAS, the declassification of the family doctor in the estimation of the patient is to the detriment of the future of modical practice and WHHERAS it is to be noted that in this resolu-

tion the term used is family dector rather than

general practitioner; be it

Resolved, that a conference be called by the House of Delegates of the American Medical Association, consisting of representatives from the American College of Surgeons, American College of Physicians, the American Hospital Associa tion, and the various specialty boards, in order to plan the future of the family doctor in future practice and in hospital organization.

The Committee approves the sentiment of this resolution, but, in recognition of the fact that the

d

American Medical Association has recognized the term "general practioner" by its establishment of a Session on General Practice, it prefers to accept that designation of the family doctor

I move the adoption of this report

DR PORTER A STEELE. Ene I second the mo-

SPEAKER ANDRESEN Is there any discussion? DR BENJAMIN M BERNSTEIN, Kings A friend of mine, a cardiologist, was called on the telephone the other day and told by a patient, not a doctor, "Will you please come over as soon as you can? I He said, "Is that pain of yours only in front or is it in back, too?"

"Oh," she said, "I have no pain in the chest I have anging of the throat I did not want a cardi-

ologist at all I just wanted a doctor "

That is not funny, gentlemen In my humble opinion, and in the opinion of the American Medical Association and others more keenly interested, the future of the practice of medicine is in Just think of the number of specialists who are being turned out A man who gets an internship of one year, then a residency for two, or three, or four years, then takes his Board, is a specialist Well, those of you who are in country practice, and those of you who are old-timers in the practice of medicine, know that a man who has had three or four years of internship and residency cannot be called a specialist, yet he gets a diplomateship, and he puts himself up as a specialist. Then what happens? The next thing he goes to a hospital, and has the hospital adopt the plan whereby only those who are diplomates in particular specialties may be placed on the staff If a man is on that staff who has not a diplomateship, he cannot survive, he cannot progress, he cannot be promoted Well, that is one of the two horsemen who are after the family doc-One is the specialty board itself, the second is the hospital Finally, the third horseman, and the important one-perhaps you may not agree with me on this, but I am accustomed to that—is the growth of what we call group medicine

What is group medicine? We point to certain institutions throughout the country, particularly the one in the Middle West, as an outstanding example of the best kind of medical practice because it is a group clinic, a very outstanding group clinic Well, if a patient came to me, and I happened to be a gastroenterologist and a specialist, and not a general practitioner, and he had a pain in the belly, and also had something above the diaphragm, I would say, "I cannot take you You will have to go to the "I cannot take you You will have to go to the cardiologist" Then if you wanted to go a step further, if he went to the cardiologist, and the cardiologist said, "Where else have you a pain?" and he replied, "I have some pain in my back," the cardiologist would have to say because of that, "I cannot look at you You will have to go to the orthopedist" Gentlemen, the thing is becoming an absurdity and

very costly to the practice of medicine

I choose to use the term "family doctor" in all due respect to Dr Flood and the Reference Committee, because the family doctor is the one who has known the patient well We are talking about psychosomatic medicine today As you know, psychosomatic medicine is not anything new When you knew all about your patient, knew about his economic, social, and sexual life, you knew the patient well, and were able to tell him or her that the emotional storm. the emotional conflict, that occurred from time to time was the thing that was either aggravating the or-

ganic disease or was producing a symptom complex and had nothing to do with organic disease member, there are some people who come to us outside of the ones who are ill with infectious disease or ill with some other condition that can be treated by specific methods Seventy per cent of the others are psychosomatically disposed individuals who have symptoms which have nothing to do with organic disease

The mere fact that a man is a doctor does not mean that he always remains a doctor In connection with the change of a doctor to a specialist I am reminded of one story which will only take me thirty seconds to tell It concerns a man who came to a small town There was only one hotel in the town, and it had no room for him He begged and pleaded, and finally, because it was late in the night. the landlord was persuaded to let him in a room that had two beds in it and where a gentleman was al-ready sleeping. When he got up at six o'clock the following morning to catch a train, it was rather dark, so he did not make a light but hurned with his When he got to the street, a man came along and saluted him, and then another did the same thing He finally made the train, and when he looked down he found himself in the suit of a general, and he said, "What a darned fool the innkeeper is! I asked him to wake me up instead of the general"

The question was called, and the motion was put to a vote, and was carned

Section 112 (See 27)

Report of Reference Committee on Report of Council-Part VI Group Practice

DR EDWARD P FLOOD, Bronz Your Committee considered the resolution introduced by Dr Alfred M Hellman, of New York, subject, "Group Prac-

"Whereas, group practice is of increasing interest in the profession because of various prepayment plans which seek to encourage the practice of medicine in groups, and

"WHEREAS, there are no largely accepted principles governing the practice of medicine in

groups, and "WHEREAS, it is desirable that the American Medical Association supervise this development rather than forfeiting it to organizations not affiliated with organized medicine, therefore be it "Resolved, that the delegates of the Medical

Society of the State of New York instruct its delegates to the American Medical Association to prepare a resolution to that body that will bring about the provision of a bureau or council on group practice, the functions of such bureau will

(a) To serve as a clearing house of information on group practice throughout the United States

(b) To formulate professional, ethical, and other principles governing the development of such group practice

(c) And ultimately, at its discretion to provide for qualifications and recognition of groups engaged in group practice in the various parts of this country "

The Reference Committee recommends the adoption of this resolution in its entirety, and I so move The motion was seconded, and as there was no discussion, it was put to a vote, and was unani-

mously carried

DR. JAMES R. REULING (Treasurer) Might I make a statement and a request? The statement is having a very high regard for the intelligence of this House, and the whole House having heard all of the whereases read either yesterday or this morning, the Chairman of the Reference Committees read just a part of the resolutions containing the resolved clauses I make it as a suggestion or a motion, if you care to handle it in that way

SPEAKER ANDRESEN We will have it as a sug

Dr. FLOOD There is only one more resolution.

Dr. REULING I am not referring to your reference committee alone but to all others who will report from now on.

#### Section 113 (See 26)

Report of Reference Committee on Report of Coun cil-Part VI Group Practice

Dr. Edward P Flood, Bronz. Your Committee considered the resolution introduced by Dr Scott L. Smith, of Dutchess County, on group practice and recommends its favorable consideration by Council of the Medical Society of the State of New York

"Wheneas, the complexity of medical knowl edge makes necessary close cooperation of practicing physicians and pooling of their various skills

"Whereas recent ensetment of laws in this State make legal provision for such combinations and associations in the practice of medicine in the several specialties, and

"WHEREAS possibilities of ethical abuse under such legal permission are not inconsiderable, and

"WHEREAS, further enactment of law broadens the conditions under which corporations and associations of laymon may employ physicians in furnishing medical care for their subscribing mem-

bers, therefore be it

Resolved, that the Council of the Medical
Society of the State of New York be requested to furnish in as much detail as possible the partner ship and group practice regulations, financial agreements and permissible participation with laymen under which the members of Organized Medicine may practice their profession.

I move the adoption of this portion of the report. The motion was seconded, and as there was no discussion it was put to a vote and was unani mously carried.

Dr. Floor I now move the adoption of the report as a whole signed by the following members, Goodwin A. Distler, Stephen H Curtis C. A. Prudhon, Porter A. Steele and Edward P Flood, Chairman

The motion was seconded, and as there was no discussion, it was put to a vote, and was unani mously carried.

SPRAKER ANDRESEN Thank you Dr Flood!

Section 114 (See 22)

Report of Reference Committee on New Business A Distribution of Medical Care

Dr. Leo F Shirson, Monrot. Resolution introduced by Dr. Reginald A. Higgons of Westchester concerning 'Distribution of Medical Care

"Whereas, the proper distribution of medical care is one of the major problems to be solved by present-day Organized Medicine if bureaucratic controls over medicine practice are to be avoided

"WHEREAS, since the war there appears to have been a trend towards even greater concentration of medical practitioners in the large urban and suburban areas, now, therefore, be it

"Resolved, that the Medical Society of the State of New York shall collect information from each County Society yearly and shall maintain an upto-date registry which will enable prospective practitioners of medicine to determine with greater accuracy which communities in the State have need for their particular type of service and which communities already have adequate medical care. and be it further

'Resolved, that the existence of such a registry shall be publicised through the NEW YORK STATE JOURNAL OF MEDICINE, the faculties of all Grade-A medical schools, and the chief of staff of each hospital approved for intern training in the

State of New York.

Your Reference Committee believes that the pur pose of this resolution will be adequately served by the issuance of the Medical Directory of the State of New York within a few months, and that the establishment of such a registry would be an unnecessary expense to the Society

We believe also that this type of information is rarely sought by prospective practitioners and that the stimulus for them to do so should originate in the medical schools and hospitals

Your Committee suggests that the Medical Society of the State of New York, through its publica tions and by any other available means, solicit the cooperation of the medical schools and hospitals in this matter

Your Committee recommends that this resolution be referred to the Council for consideration and

action, and I so move

The motion was seconded, and as there was no discussion, it was put to a vote, and was unanimously carried.

#### Section 115 (See 25 77)

Report of Reference Committee on New Business A: Specialty Board

DR. LEO F SIMPSON Monroe. Concerning the alternate resolution introduced by Dr LaGattuta, of the Bronx, subject Specialty Board, 'and read-

"WHEREAS, it is the policy and sim of the American Medical Associaton to foster affiliations of all physicians with a hospital in order that they might continue their education and increase their efficiency and

"WHEREAS, interference in doctor hospital relationship is influenced by the indirect action of the

various specialty boards and

WHEREAS, on account of the numerous complaints from returning veteraus being unable to qualify for the board on account of a lack of available and acceptable residencies and

"WHEREAS this condition is prevalent through

out the country, therefore, be it

Resolved, that delegates of the Medical Society of the State of New York be directed to memorial ize the House of Delegates of the American Medical Association at its forthcoming June meeting in Atlantic City that the Board of Trustees be requested to appoint a committee for the purpose of investigating the Hospital-Specialty Board relationship, and to take whatever means necessary to correct the situation.

Your Reference Committee approves this resolution and recommends its adoption. I so move

The motion was seconded, and as there was no discussion, it was put to a vote, and was unanimously carried.

Section 116 (See 35)

### Report of Reference Committee on New Business C Podiatry

DR. THEODORE J CURPHEY, Nassau Concerning the resolution on podiatry introduced by Bronx County, this resolution deals with the attempt on the part of podiatrists to pass legislation in this State to extend the limitations of their licensure to include the treatment of systemic disease as manifested in lesions of the lower extremities and requests that the Medical Society of the State of New York place itself on record as being opposed to such legislation, and further, that the Governor and members of the Senate and Assembly and also the Board of Regents of the State of New York be sent copies of this resolution

Your Reference Committee has studied this resolution and is entirely in accord with the principles outlined therein, and is of the mind that this matter be referred to the Council Committee on Legislation in order that more vigorous opposition to any proposed legislation in this connection shall be fostered directly by the New York State Society

Your Committee further feels that the Committee on Legislation, its Executive Officer in Albany, and all other Committees of the Council should be constantly alert to the threat of the extension of the activities of this group, with their resultant encroachment upon the regular practice of medicine, and should be prepared at all times to take prompt action toward preventing this group from broadening their activities to the detriment of the health and welfare of the people

I move the adoption of this portion of the report DR. CLARENCE G BANDLER, New York I second

the motion.

SPEAKER ANDRESEN Is there discussion?

DR SAMUEL Z FREEDMAN, New York Read the resolved part so we know what you are talking about

(At this point Dr Harry Aranow spoke, and later on, upon motion which was duly made, seconded and carried, was given permission to delete it from the official minutes )

Dr. FREDERICK W WILLIAMS I am sorry that Dr Curphey did not read all of our resolved's contained in that resolution. The last resolved carried that reference to the Board of Regents I would like to read that last resolved

"Resolved, that the content of these resolutions be made known to the Board of Regents of the State of New York"

We have in our folder, and have showed to the chairman of the Reference Committee copies of the State examination in podiatry The first question was, "How do you make a diagnosis of diabetes?" We have a handbook also of this Institute of Podiatry and in it they have listed that they give a course in the diseases of metabolism and other medical conditions I think they are far overstepping the rights granted to them under the Practice Act of Podiatry, which says they can treat diseases of the feet only as far as the deep fascia

I think this portion of the report of the Committee is quite acceptable except that they should include some recommendation to the Board of Regents, and I would like to move an amendment to this report that they also include that a copy of the resolution be

forwarded to the Board of Regents as well
Dr. Curphey That will be acceptable to the Reference Committee

The resolution referred to is as follows

"Whereas, podiatry is a technical minor

adjunct of orthopedics, and
"Whereas, many major systemic diseases have manifestations in lesions of the lower extremity.

"WHEREAS, the Institute of Podiatry is not a

medical school, and

"WHEREAS, the licensed podiatrists have been active in attempting to pass legislation in this State to extend the limitations of their licensure to include the treatment of systemic disease, and

"WHEREAS, the treatment of disease constitutes the practice of medicine under the laws of this

State, and
"Whereas, the passage of such legislation would be detrimental and hazardous to the public health and welfare, therefore, be it "Resolved, that the Medical Society of the

State of New York put itself on record as being opposed to such legislation, and be it further

Resolved, that the Governor and members of both Senate and Assembly be sent copies of this resolution, and be it further

"Resolved, that the Legislative Committee and our Albany representative be instructed to govern themselves accordingly, and be it further

'Resolved, that the content of these resolutions be made known to the Board of Regents of the State of New York."

The question was called, and the motion as amended was put to a vote, and was unanimously carried

Section 117 (See 91)

Report of Reference Committee on New Business C Training of Medical Technicians

DR THEODORE J CURPHEY, Nassau On the resolution introduced by Dr Alexander Newlands, of Westchester, reading

"WHEREAS, it is self-evident that an essential element of good medical care rests in a large degree upon conscientious and well-trained medical technicians, and

"Whereas, very few colleges or universities in this State offer suitable educational programs for the training of medical technicians, now, there-

fore, be it "Resolved, that the Medical Society of the State of New York memorialize the colleges and universities of the State, urging them to establish a four-year curriculum for the training of medical technologists, including a minimum of one year of supervised practical experience in an approved hospital and which will lead to a degree in Medical Technology, and be it further "Resolved, that consideration be given to a

limited program consisting of one year in basic courses and one year of practical hospital training in which certification may be granted as a junior

grade medical technologist'

The Committee has studied this resolution from Westchester County and recognizes the need for elevating the educational and technical qualifications of the nonmedical laboratory worker, and for that reason approves in principle the intent of the resolu-

The Committee further feels that the matter re-

quires detailed study and would recommend that it be referred to the Council, urging them to investigate the problem with the aid of those educational and medical organizations having a similar interest to wit the New York State Society of Pathologists the Joint Council of Radiologists Pathologists Anes-themologists and Physiotherapists as well as the Board of Registry of the American Society of Clinical Pathologists and the New York Academy of Medicino.

I move the adoption of this report.

Dr. J Lewis Amster, Bronz I second the motion.

SPEAKER ANDRESEN Is there any discussion? DR. ERRA A. WOLFF, Queens Mr Speaker and Gentlemen of the House I rise to comment on the action of this Committee I support it, but I want to take this opportunity of drawing to the attention of the House the importance of considering economic matters in relation to some of the specialties of medicine. The reason medical laboratory technicians standards have deteriorated to the lower degree that they have reached is the fact that in hospitals the pathologists are considerably limited in their use of budgetary means. As a result they have been forced to offer these technicians a poor salary As a consequence, a lot of fly by-night schools have arisen, particularly in the metropolitan area, that are now exploiting veterans' benefits. The only way to attack this problem is to support the hands of the pathologist and that has already been taken care of by Dr Flood's Committee Dr Curphey in proposing that this be referred to the Council, where it will probably get some action, should be supported In that way we may get some action initiated on a State level that will make for the solution of this problem, but we must not lose sight of the fact of the fundamental difficulty behind all of this, namely that hospital superintendents offer starvation wages to these presumably highly skilled technical per sonnel.

SPEAKER ANDRESEN Is there any further discussion?

Da. ARTHUR A. FISCHL, Queens. The only question I wanted to raise was whother by insisting they take a four year course it might not be a factor that will discourage and prevent people from studying this subject?

DR. CURPHEY I think I might be able to clear the matter up We have just accepted this resolution in principle. The Committee does not approve of the actual wording of the resolution, especially in respect to the time involved in the training of these technicians

The question was called, and the motion was put to a vote, and was carried.

SPEAKER ANDRESEN Thank you Dr Curphey!

Section 118 (See 87)
Report of Reference Committee on Report of Council—Part XII Nursing—To Provide a More Adequate Supply of Hospital Nurses

Dr. Joseph A Geis, Esser. This resolution was introduced by Dr. McGarvey of Westchester

County, on the subject of nursing

WHEREAS, there is a nation-wide nurse shortage of alarming proportions with recently compiled statistics indicating a national deficit of 40 000 nurses 16 per cent of the hespitals in the United States with closed beds and 33,000 beds in our hospitals unavailable because of the nurse shortage and

WHEREAS, in the month of April in New York

State hospitals reported 1 831 closed beds and waiting lists of 8 403 patients primarily because of nurse shortages, and

WHEREAS the national enrollment of 31,000 students in approved schools of nursing in 1946 was some 13 000 fewer than the schools sought and approximately 40 per cent fewer than the 1945 enrollment and

"Whereas, this trend and the actual shortage are of serious concern to the nation s health and

'WHEREAS the use of the bedside worker trained to perform many routine tasks in the case of bed patients in hospitals have been proved by wartime experience in both military and civilian hospitals to be an acceptable expedient to supplement the services of available graduate professional nurses to the advantage of the patient's care and "Whereas the New York State Board of Nurse

Examiners while licensing practical nurses with requisite training and qualifications prohibits the training of practical nurses in any hospital maintaining a school for the training of graduate

professional nurses, and
Wheneas the best facilities for the training of those concerned with the care of the sick are generally to be found in those hospitals with

approved schools of nursing and "Wheneas, short orientation courses for socalled attendants or nurses-aides do not appear to offer a satisfactory solution to the problem of better and more adequate bedside care now therefore be it

'Resolved, that the Medical Society of the State of New York go on record as endorsing an exten-sion of the training program for practical nurses in addition to its continued efforts to increase the available supply of registered professional nurses and be it further

Resolved that the Medical Society of the State of New York, in cooperation with the State Board of Nurse Examiners and the New York State Hospital Association, seek liberalization of the inter-pretation of existing laws so as to permit the training of practical nurses in all hospitals now con ducting training schools for registered, professional nurses and be it further

Resolved that the Medical Society of the State of New York urge the establishment of training programs for practical nurses in approved hospitals not at present conducting a nurse train

ing program of any sort and be it further "Resolved, that the American Medical Association be petitioned to take similar action urging similar steps nationally with the offer of active cooperation with other national bodies concerned with the training of nurses.

Your Reference Committee approves this resolu tion, and I so move.

DR. HOMER J KNICKERBOCKER, Ohlario I second the motion.

DR. SAMUEL Z FREEDMAN New York. That was for the approval of the resolution?

SPEAKER ANDRESEN 1 cs Is there any discussion on the motion of the Reference Committee which is to approve this resolution?

Assistant Segretary Freet In discussing this while I am in favor of it, I would like to call to the attention of the House the fact that at a meeting in Buffalo eighteen months ago the House of Delegates authorized, and I quote, the establishment of an independent coordinating board representing nurs-

ing hospital administration, and medicine the delegates being authorized, subject to the governing

bodies of each representative group, to outline broad policies of cooperation," etc. Such a board has been set up with our Council Committee on Nursing as one of the integral parts, with representatives of the hospital administrators, nurses and practical nurses, and where many of these problems are now under consideration

I think the membership of this House should realize that, and resolutions of this kind might well

be referred to that committee for its action

The question was called, and the motion was put to a vote, and was unanimously carried

Section 119 (See 86)

Report of Reference Committee on Report of Council—Part XII Practical Nursing

DR JOSEPH A. Geis, Essex Resolution introduced by the Orange County Medical Society, reading

"WHEREAS, the availability of properly trained nurses is obviously inadequate to accomplish hospital and private home requirements, and when available such services are costing beyond the financial capacity of the majority of patients,

"Whereas, an estimated two thirds of the population of the county desire and need simple nursing and housekeeping assistance during illness such as is customarily rendered by acceptable practical nurses at charges commensurate with

average family income, and "Whereas, acceptable practical nurses can be developed through approved training schedules covering essentials of nursing care, either in recognized hospitals or under personal guidance of practicing physicians, and such practical nurses can and do become able assistants to physicians within the financial capacity of the

average family, and
"Whereas, New York State—Chapter 472 of
the Laws of 1938—amending the Education Law, has prohibited Practical Nursing except by trained graduates of nine months' instruction at special schools, and in view of the request of the Board of Regents that the law be repealed, has almost wholly failed to produce a sufficient number of practical nurses and clearly seems to be

against the public interest, and

"WHEREAS, all the other states of the Union permit practical nurses to function under the supervision and responsibility of the practicing physician, and twelve of them have abandoned compulsory licensure, therefore, be it

"Resolved, that the Medical Society of Orange County request the Medical Society of New York State to take action leading to the repeal of this law"

The present law was introduced by the State Nursing Association and endorsed by the representative committee chairmen of the various county The operation of this law has medical societies been postponed each year since its passage due to war conditions Therefore, this Reference Committee thinks it has not been given a fair trial and disapproves of this resolution at this time

We would suggest, however, that the Council Sub-Committee on Nursing consider the advisability of action at some time in the future

I move the adoption of this report

DR V LEONARD WILLIAMS, Kings I second it SPEAKER ANDRESEN Is there any discussion on the motion to adopt the report of the Reference Committee, which carries with it disapproval of the resolution?

DR M R BRADNER, Orange The resolution has for its purpose the amplification of the previous resolution to provide training courses for practical nurses in all approved hospitals, so that they may receive their training near home and get on the job in a hurry, thus providing us with practical nurses which we need because of the real dearth of trained This 1938 law, however, makes it compulsory for these pupil nurses to receive their training at certain specified points set up for that purpose It encourages the younger women to take the courses and discourages the older women from doing so The only state in the United States today that is even considering a compulsory registration of practical nurses is New York State, and they have held the enforcement of that law in obeyance now since 1938, during which time the courses that have been given have been such that the State Regents has suggested the repeal of the law as being detrimental to the production of practical nurses

Our resolution was intended to expedite the actual training of practical nurses by rescinding this law which hampers the whole procedure, and has as its purpose the abolishment of the law and the removal of this threat of compulsory registration and the providing of training courses for practical nurses

in hospitals near their homes ASSISTANT SECRETARY FREY This is a matter that the Council Committee on Nursing and this Coordinating Board on Nursing Problems have considered at length The present requirements under this law that Dr Bradner would like to see repealed are for nine months' courses of training minimum for practical nurses, of which three months are to be didactic and six months are to be in training schools It is recognized that there are not of some sort enough training schools for practical nurses, and that their distribution is not good. There are none here in the western end of the State There is one in the Albany region but none in the northern part of the section

I think, however, it would be a mistake to lower the standards any more than they now are This law about the registration of nurses becomes mandatory next year, and of course it will not be retro-active. Those that are now practicing will be allowed to continue to practice. Therefore, the allowed to continue to practice Therefore, the recommendation of the Reference Committee can well be supported

SPEAKER ANDRESEN I will recognize Dr Smith, but I have been asked to request Dr Lochner to dis-

cuss this as soon as Dr Smith is through

Dr. Scott Lord Smith (District Delegate) I feel a very strong sympathy for Dr Bradner in his It was my impression of the law when resolution it was first proposed and later enacted that it would not supply an adequate number of so-called practical nurses for the reason that, in our district at least, the bulk of women who call themselves practical nurses are women who for some reason or another have had to change their manner of life For the most part they have had to support themselves later in life They have had some experience in their own homes, most of them are married women and know a little bit about taking care of people, and they furnish a very acceptable means of taking care of the sick. That law, it stands now, only allows people to become practical nurses who take a special course Most of these women who supply the bulk of the work that is done in Dutchess County, for instance, have not the time nor the financial capacity to take

such a course. They are further along in life. There is no incentive, particularly to the younger women. to take such a course. They can make more money doing something else and they don t want to take that length of time to do that work. We have any number of women who come under the so-called waiver year after year, and if we can get more people who can do the same thing, or unless some radically different way of supplying nurses is considered, the hideous shortage of practical nurses, in my judgment, is going to be continued.

SPEAKER ANDRESEN Dr Lochner will you en

lighten us for a moment about this?

DR. JACOB L. LOCHNER, JR. Mr Speaker, the Board of Regents suggested that the act licensing practical nurses be repealed in order to see what the situation was There was a hearing held in Albany before the Board of Regents on this, and the room was packed with representatives from nursing organizations and the State Medical Society was represented by Dr Anderton and Dr Hannon, and it was the opinion of the majority at that meeting that no repeal should be instituted at the present time. Therefore, the Chancellor of the Board of Regants appointed a committee to study this situation and report back in a few months.

Is that what you want?

SPEAKER ANDRESEN 1es
DR. THOMAS A. McGOLDRICK (Past President)
And he did appoint such a committee?

DR. LOCHNER Yes.
DR. McGoldrick Who are they?

DR. LOCHMER I don't know
DR. ANTHUR A. FISCHI, Queens Dr Frey made a
statement to the effect that this was not to be
retroactive. There was some question in my mind as to whether this is retroactive or not because it has been brought to my attention that a number of practical nurses who have been working in institutions are very much afraid that they will lose their positions if they are not already certified. I would like to ask Dr Frey if he knows definitely whether or not this is retroactive.

ASSISTANT SECRETARY FREY I don't know SPEAKER ANDRESEN The motion is the adoption of the recommendation of the Reference Committee which disapproves of the resolution. An affirmative vote means that the resolution of Orange County is

disapproved.

The motion was put to a vote and was carried.

Section 120 (See 78 72)

Report of Reference Committee on Report of Planning Committee for Medical Policies Group Prac tice and Partnership

Dr. Thomas M. D Angelo, Queens The following resolution introduced by Dr. Aaron Kottler of Kings County dealing with Group Practice and Partnership was referred to this Reference Committee for study

"Wheneas, the New York State Legislature enacted Senate Introductory 740 Printing 2142 in the 1917 Legislature which is now a chapter of the laws of 1917 of the State of New York and

"Witereas said law amends the Education Law in relation to the practice of medicine by physicians as partners and permits the pooling of fees and monies for medical services by the members of the partnership or group and employees of such Partnerships or groups, and WHEREAS, said bill does not specify or limit

the number of partnerships or groups to which an

individual physician may belong and
Wheneas under the present bill, a physician might be a member of more than one group and use this as a subterfuge for fee splitting, and also create a situation where said member of more than one partnership might be tempted to render services for less than the agreed fee among the

group and "WHEREAS, said bill permits a division of the fees with an employee who does not necessarily have to be a physician under the terms of the bill,

therefore, be it

"Resolved, that we request that legislation be introduced in the 1948 session of the New York State Legislature amending the recently enacted law concerning group practice or partnership, and incorporating therein provisions or amendments to correct the foregoing objections

At this morning a session your Reference Committee covered the proposals embodied in this resolution

"The Committee notes the enactment into law of bills to permit physicians to practice in partnership and to pool fees, and to allow on the provisions of IX-C of the Insurance Law, the employment of physicians by nonprofit medical indemnity and hospital service corporations to treat persons in-sured by them. The State Society opposed this legislation because we felt that the bills were loosely drawn and opened up avenues for flagrant violations of medical ethics and that would be contrary to the best interests of the people Reference Committee endorses the recommenda tion of the Planning Committee that the House of Delegates authorize the Council to have drafted suitable legislation to cover the matter of partner ships and group practice within the principles already approved by the State Society

Your Committee feels however that this resolu tion can be approved in order to reaffirm our stand in

this matter I so move.

The motion was seconded, and as there was no discussion it was put to a vote, and was unanimously carried.

Section 121 Report of Special Committee to Review the Principles of Professional Conduct with Reference to

Advertising

SPEAKER ANDRESEN I would like to call on Dr Charles N Allaben, who has been waiting for a long time to be recognized. Dr Allaben is reporting for the chairman of the Special Committee that was appointed by this House a year ago to review the Principles of Professional Conduct Dr Brennan is

the chairman, and he could not come.

DR. CHARLES N ALLABEN (Councilor) Thomas M Brennan, the chairman, was to give this report, but he was detained in Brooklyn, so I will give this report that came this afternoon after

lunch "At the annual meeting of the House of Delegates held in October 1945 a resolution was passed as follows

WHEREAS, Section 31 of the "Principles of Professional Conduct of the Medical Society of the State of New York falls to specify precisely what may properly be stated in the advertisement or announcement of a book, article or other publication written by a doctor for the laity therefore be it

"Resolved, that a special committee be appointed to study this problem and formulate such necessary amendments as the committee deems advisable"

"Your Committee has discussed this problem in an effort to formulate amendments that will cover only what can be stated in an advertisement or announcement of a book, article, or other publication written by a doctor member of our Society for the laity. The Committee finds it practically impossible to formulate an amendment or amendments which would cover all and every question as to what should be stated in the announcement of any book, article, or publication that any member of the Society might wish to publish or print. It seems, however, quite feasible to require that the proposed advertisement or announcement, as well as the book, article, or other publication, be submitted for review to a Council committee and passed upon prior to publication. The Committee recommends the following resolution

"Members of this Society who have prepared and written a book, article, or any writing pertaining to medicine, for the laity and intended for publication, shall submit the same to the Council Committee on Public Relations and the Public Relations Bureau of the Medical Society of the State of New York for approval prior to any publication thereof In the event the book, article, or writing shall be so approved for publication, then and in that event any proposed advertisement for or announcement of publication thereof shall be likewise submitted to the said Council Committee and Bareau for approval prior to any appearance thereof in print The reviewing committee shall render its opinion without unnecessary delay This Committee shall be in the main guided by Section 31 of the 'Principles of Professional Conduct' but shall be empowered to make such concessions as may be practiced and neces-sary in considering the title of the publication, the description of the content, the responsibility, standing, and reputation of the writer and such other material through which the publisher wishes to arouse reader interest "

I move the adoption of this report The motion was seconded

SPEAKER ANDRESEN Is there any discussion? DR. BENJAMIN M BERNSTEIN, Kings The Committee on Public Relations of the Kings County Medical Society about three weeks ago had two subjects sent to it for approval. After reading the Code of Ethics very carefully, we decided, regardless of what the content of these articles or what have you. are, that if we follow the Code of Ethics of the State Society-and we must follow that-we have no choice but to refuse to permit any publication of any book or any article in the lay press or the appearance before the radio of any man when he is introduced as being Doctor X-Y-Z, associate professor, or clinical instructor, or what have you, of any organization, because the Code of Ethics says explicitly no doctor shall advertise to the laity by word of mouth, or letter, or radio, or what have you, in such a way as to call attention to himself as a doctor words, he cannot have his name mentioned in connection with what he does in the practice of medicine to draw attention to himself We cannot possibly censor these articles as far as the present Code of Ethics is concerned, so there must be a change in the content of the Code of Ethics

The question was called, and the motion was put to a vote, and was unanimously carried

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Section 122

Report of the Reference Committee on Report of Council—Part V Rehabilitation and Rural Medical Service

DR A. N SELMAN, Rockland Your Committee on Rural Medical Service, under the chairmanship of Dr Dan Mellen, of Rome, functioned to plan for improvement in rural health, and made themselves available for conference and advice to the American Farm Bureau Federation The Committee also worked with a Committee on Veterans' Postwar Affairs to help fill vacancies in rural communities Members of the Committee represented New York State in the National Conference on Rural Health, held in Chicago in March, 1946, ably attesting to the national organization that New York State is actively interested in the betterment of medical care in rural areas. The activities of this committee are commended, and your Reference Committee advises that this committee be continued. I so move.

The motion was seconded, and as there was no discussion, it was put to a vote, and was unani-

mously carried

DR SELMAN The Subcommittee on Rehabilitation, under the chairmanship of Dr O W H. Mitchell, of Syracuse, developed a close and extremely valuable liaison with the Bureau of Medical Rehabilitation, the State Department of Health, the Division of Vocational Rehabilitation of the State Education Department, and the State Department of Social Welfare They should be commended for their efforts and success in effecting this cooperation, and your Reference Committee recommends that this Committee be continued

I move the adoption of this portion of the report The motion was seconded, and as there was no discussion, it was put to a vote, and was unanimously carried

• DR SELMAN Now I move the adoption of the report as a whole

The motion was seconded, and as there was no discussion, it was put to a vote, and was unanimously carried

SPEAKER ANDRESEN It is now five o'clock. Shall we go on for another hour or so, and see what we can clear up, so there will be a minimum of business left over for to prove more than the same seems.

over for tomorrow morning? Chorus Yes, continue!

Section 123 (See 6)

Reference Committee on Reports of the Treasurer, Trustees, and Finance Committee

Dr. John D Naples, Eric Referring to paragraphs one and two of the Supplementary Report of the Board of Trustees, which read as follows

"1 That a business survey be made of the greatly extended activities of the Society during the past eight years by a competent firm or other qualified persons, such firm or persons to be chosen by the Council or a Committee thereof, appointed by the President of the Society, subject to the approval of the Board of Trustees, and under the direction of the Council, in order that the efficiency of the Society be increased, the relationship of expenditures of various departments to the over-all efficiency of the Society be evaluated, and such changes be made in the administration of the affairs of the Society by the Council upon the recommendations made in the report submitted after survey, subject to the approval of the Board of Trustees, as to the entailed expenditures only

"2 That a new committee of the Council be

created entitled the Committee on Committees, to be composed of the Chairman of each of the Council Committees, the President, the President Elect the Past-President, and two additional members to be appointed by the President with the approval of the Council. This Committee would act to coordinate all of the functions of the Council Committees so that unnecessary over lapping of functions would be diminished integra tion of all of the work of the Society be made more efficient, and unnecessary expenditures be less-

As to the foregoing paragraph, your Reference Committee recommends that the House of Delegates approve the principle of conducting the management and administrative affairs of the Society in the most efficient manner possible It is recommended that the House of Delegates refer these matters to the Council the constituted committees, and the Board of Trustees for study and such action as may be

deemed appropriate.

The Reference Committee moves the adoption of

its report as to paragraphs 1 and 2.

The motion was accorded and as there was no discussion, it was put to a vote, and was unani mounty carried.

DR. NAPLES Referring to paragraph three of the Supplementary Report of the Board of Trustees, which reads as follows

It is further recommended that careful consideration be given by the House to the fact that in the very near future the activities of the Society limited as they must be by our Dues In-come, must of necessity be directly designed on the annual assessment of the members increased The Board desires to bring to the attention of the House the fact that the per capita dues of this Society are the lowest of those of any of the other State Societies of the United States comparable to the total State population or the total number of members of these Societies. A list of these Societies will be furnished the House in the Report of a Committee of the Council.

The Reference Committee does not have sufficient knowledge on this subject to make a specific recommendation. However the Committee does believe that an increase in the State assessment is definitely needed to compensate for rising costs of operating the State Society's activities

The Reference Committee recommends that the matter of increased dues be referred to the Council and Trustees for study during the ensuing year and that they be prepared to submit to the next meeting of the House of Delegates a definite recommendation on the subject.

The Reference Committee moves the adoption of

its report as to paragraph 3
DR. JAMES R. REULING (Treasurer)
Gentlemen, I rise to make a substitute motion for this reason If this is referred to the Council and the Trustees for study it is going to be 1949 before we can get an increase of dues. I, therefore offer a substitute mo-tion that this House of Delegates approve an assessment of \$15 for the year 1948.

The motion was seconded by several PRESIDENT BAUER I think you will recall that in my report I recommended that the dues be increased. The Committee took no action on it, I think properly, because this other committee had the same subject under consideration. I would agree with Dr Iteuling that if we put it over it will be 1049 before we can get any increased income. Already

the State Society is operating beyond its dues income and although we have been very fortunate during the war to stay in the black, the past year there was a slight deficit. It is true that the exten sion of the time in which the men coming back from service to have their dues remitted will soon be up probably by the end of this year and our income will be somewhat increased it still will not be enough to carry on our activities We have got to do one of two things We have got either to increase our dues. or we have to cut down our activities. I submit to you gentlemen that now is no time to cut down on our activities. We have approximately 21 000 members in the Society That brings in an income of \$210,000 The budget which was submitted to the Council and by the Council to the Board of Trustees for 1947, amounted to about \$230 000 which is \$20 000 more than our estimated dues income, and out of that there will be some remissions of dues too It is true that usually our budgets are in excess of our actual expenditures but I think in all probability our expenses this year will again exceed our dues in come, and I would like to second Dr Rouling's motion to substitute for the Committee s report a motion that our dues be increased commencing January 1, 1948 to \$15.

Dr. Januar F Roover (Trustee) Mr Speaker

and Gontlemon of the House, I am very glad indeed to have this matter brought before you because I have listened with great care to the amount of additional work, which is going to require additional expenditures, that has been thrown upon the ad ministration of this Society by your actions today on these matters that you have referred to the Council. I should estimate that in all probability in order to carry out your wishes as expressed in your actions today, there will be an additional expenditure of at least \$25 000 to \$45 000 entailed in relation to the expense of the various committees and aubcommittees of the Council that will have to carry on this work. I feel that we are going to have a need of this money now not in 1949 unless we are going to have to sell cortain of our investments at a loss in the present market.

I desire to second in every way the motion made by Dr Reuling, and I hope you will see the necessity of this measure contiemen, and that you will vote that we may be able to secure this money beginning at least with the annual dues of 1948.

SPEAKER ANDRESEN If there is no further discussion, the motion is to substitute Dr Reuling s motion for the motion of the Committee, which is in offect an amendment.

Themotion was put to a vote and it was carried.

SPEAKIR ANDRESSIN We now have the motion that was substituted for the original motion before us Is there any further discussion?

The motion was put to a vote, and was

carried.

DR. NAPLES The Committee has reviewed the report of the Treasurer with approval and recommends that it be accepted as presented. Reference Committee moves the adoption of its report on the Treasurer s report.

The motion was seconded, and as there was no discussion, it was put to a vote and was unani

monely carried.

DR. NAPLES With respect to the report of the Finance Committee regarding the war memorial of the Society which is a proposal for the Society to finance the advanced education of the children of its members who died in military service during World War II your Committee feels that this can

only be financed by a special assessment for this pur-Your Committee recommends that this matter be referred to the Council and Trustees for further study as we have no factual or actuarial knowledge as to its present or ultimate costs

The Reference Committee moves the adoption of its report on the Finance Committee's proposal for a

war memorial.

The motion was seconded, and as there was no discussion, it was put to a vote, and was unanimously carried.

Dr. Naples Now the Reference Committee moves the adoption of its report as a whole, with the

substitution.

The motion was seconded, and as there was no discussion, it was put to a vote, and was unanimously carried

Section 124 (See 85, 79)

Report of Reference Committee on Report of Council—Part X Workmen's Compensation—Medical Practice Committee

DR. F. W. HOLCOMB, Ulster Before presenting the report of the Council, Part X, on Workmen's Compensation, there are three resolutions that I would like to present and have your endorsement on Two of these resolutions are identically the same One of them was introduced by Dr Dwight V Needham, of Onondaga County, and the other by Dr Aaron Kottler, of Kings County These are, as I said, almost identical in wording, and I will leave out the whereases and read just the resolved part

"Resolved, we request that the Council of the Medical Society of the State of New York, through its Committee on Legislation be instructed to prepare and introduce legislation calling for the abolition of the Medical Practice Committee and the restoration of its functions to the respective county societies"

The other one reads

"Resolved, we request that legislation be intro-duced in the New York State Legislature in the 1948 session to restore to the county medical societies of Greater New York the powers which they had under the compensation laws in 1935"

Your Reference Committee recommends approval

of both of these resolutions, and I so move.

The motion was seconded, and as there was no discussion, it was put to a vote, and was unanimously carried

Section 125 (See 89)

Report of Reference Committee on Report of Council-Part X Request for Opinion Regarding Compensation Ratings of Physicians

Dr. F W Holcomb, Ulster On the resolution introduced by Dr Porter A. Steele, of Erie, subject, "Request for Opinion Regarding Compensation Ratings of Physicians," and reading

"WHEREAS, the 1947 State Legislature enacted a law which permits the Chairman of the Work-men's Compensation Board to review and revise the compensation ratings of physicians, and "Whereas, the Chairman may use this power

to revise ratings granted before the effective date of this new law, therefore, be it "Resolved, that the counsel of the Medical Society of the State of New York be called upon to render to the physicians of this State a legal opinion as to whether this new law applies to ratings granted before the law was enacted.

your Reference Committee approves the resolution and recommends that it be referred to our legal I so move counsel.

The motion was seconded, and as there was no discussion, it was put to a vote, and was unani-计划之次 mously carried

Section 126 (See 15, 18)

n Sie Report of the Reference Committee on Report of Council-Part X Workmen's Compensation

Dr. F W Holcome, Ulster The report of the Workmen's Compensation Committee is so replete with details and information concerning the activities of the Committee during the past year that your Reference Committee can comment only on the more important matters and recommendations contained therein

Your Reference Committee endorses the recommendations of the Committee that the County Society Compensation Committees hold regular meetings to consider the problems arising under the Workmen's Compensation Law and to carry out adequately the functions devolving upon the societies

We commend the spirit of cooperation between the county societies and the State Committee and the Bureau of Workmen's Compensation The proper administration of the Workmen's Compensation Law and the protection of the interests of the medical profession can be furthered by close relationships between the county society and the State Committee, the Workmen's Compensation Board, insurance 4carriers, and employers

While your Reference Committee makes no comment on the cost of those services and how they should be met, they are reflected in the cost of running the Society and may eventually justify an ? increase in the State Society dues It is proper in this connection to draw attention to the statement in the report to the effect that under the old fee schedule physicians during the past few years have enjoyed an income annually of between twenty to thirty million dollars from workmen's compensation cases alone

Your Reference Committee approves the organization of the Joint Medical Conference Committee, comprising representatives of the Medical Society, insurance carriers, and employers It also endorses the recommendation of the Workmen's Compensation Committee that local joint committees be orgamzed throughout the State. In the smaller societies, groups of adjoining counties together may form a joint council to discuss workmen's compensation problems and to act in concert with the central joint medical conference committee The many items of interest reported or discussed by the conference often lead to decisions of mutual advantage and justify the above approval.

I move the adoption of this portion of the report There being no discussion, the motion was put

to a vote, and was unanimously carried DR. HOLCOMB According to the report for 1946 of the Chairman of the Workmen's Compensation Board the direct cost of workmen's compensation for this year was close to \$200,000,000 aside from the economic loss to workers and their families and to industry and Since medical service is the keystone in this great structure of social advancement, we commend the efforts of the Chairman and members of the Workmen's Compensation Board and their staffs This bespeaks a close and harmonious relationship between this State agency and the State Medical Society to the end that the administration of the Workmen's Compensation Law may be acilitated in the public interest

The free choice principle must be safeguarded by appropriate cooperation on the part of the medical profession in providing the highest quality of medical are at a reasonable and fair cost to the employers and their carriers Your Reference Committee can only repeat and emphasize many of the statements of the Workmen's Compensation Committee reating to this subject

Your Reference Committee wishes to emphasize the following portion of the Annual Report

"It is the duty of every physician to comply with the conditions imposed by the Workmen's Compensation Law to treat only such patients as he is qualified, by education training, and experience and to refer to a better qualified physician for treatment all patients requiring more expert or special care than he can render This is a moral and ethical duty and its strict observance will go a long way to justify and perpetuate the 'free choice' principle in the Compensation Law As it is the duty of the Workmen's Compensation Board to improve the administration of the law to the end that claims may be settled without delay so too, it is the duty of the physicians to cooperate with the authorities to bring about prompt and accurate reporting and appearing before referees when necessary

Prolonged treatment or improper medical care may keep the employee out of work beyond the time necessary to restore him to health and work Neither the importunities of the patient (who does not pay the bill) nor the expectation of greater fees should interfere with sending the patient back to his job as soon as medically indicated. Under the Workmen's Compensation Law a physician is unlimited in his calls upon the resources of the medical profession in order to get the patient back to work promptly The medical societies through their compensation committees and with the cooperation of the employers and the insurance carriers have a unique opportunity to be of service. We urge them to give great consideration

to these problems.

I move the adoption of this portion of the report.

The motion was seconded, and as there was no discussion it was put to a vote and was unani-

mously carried

DR. HOLCOMB Your Reference Committee commonds the Committee for its efforts to bring about a revision of the workmen a compensation fee schedule If the best qualified physicians in the State, and over 22 000 physicians have been authorized to treat compensation claimants are to be available for treatment the fees paid must be adequate. Low fees out of line with fees paid by private patients of a like standard of living combined with the necessary burden of making out and filing reports will have a tendency to discourage physicians from ac-

cepting compensation claimants
Your Reference Committee learns with some satisfaction of the partial revision of the Workmen s Compensation fee schodule announced on May 5 by Miss Donlon. Her action based upon the report of her Advisory Committee is appreciated as a step in the right direction. We urge that the Advisory Committee give prompt attention to the upward revision of the remaining items in the fee schedule proposed by the President of the State Medical Soclety in accordance with the provisions of Section 13 of the Workmen's Compensation Law I move the adoption of this portion of the report.

Dr. RALPH SHELDON Wayne I second the motion.

SPEAKER ANDRESEN Is there any discussion? DR. ABRAHAM KOPLOWITZ, Kings I would like to second this part of the report My motion is that the delegates of this House express their gratitude to Dr Van Etten and his Committee for their work and

our appreciation to Miss Mary Donlon for her understanding and fairness

Dr. Holcoms That is at the end of the report if you will bear with me until then.

Dr. Lortowrrz Oh it is?

Dr. HolcoxB 1cs

The question was called and the motion was put to a vote and was unanimously carried

Your Reference Committee Dr. Holcomb learns with concern of the refusal of the Chairman of the Workmen's Compensation Board to authorize physicians in the employ of the State as psychia trists and pathologists to treat compensation claimants although the Commissioner of Mental Hygiene favors such authorization and has no objec-tions thereto This deprives certain localities of the State of the services of certain specialists not other wise available in compensation and other cases urge the Chairman of the Workmen s Compensation Board to reconsider this matter in the light of this recommendation.

Dr. Harry Aranow (Councilor) If I understand it correctly the reason she refused it was because she

felt they were occupying another State Job Dr. Holcoup That is right. That was her reason I believe, for refusing it but as we have pointed out in certain localities in the State there are only a few men who are qualified to do this work, and their services are needed at times

I move the adoption of this portion of the report

The motion was seconded, and as there was no further discussion, it was put to a vote, and was unanimously carried.

DR. HOLCOMB County societies are admonished Dr. Hollouis County societies are admonstaged to read carefully the report of the Committee on Professional Qualifications and to carry out the recommendations carefully We quote from the report

'We believe the determination of professional qualifications should be the function of the medical societies and remain within the province of or ganized medicine. Standards should be suffici ently high so that a physician who is rated as a specialist under the Workmen's Compensation Law will be regarded with the same confidence and respect as the holders of National Board specialty diplomas and members of the American Colleges Our standards are such that if the county medical society workmen's compensation committees adhere closely to them, the recipionts of specialists symbols will be of such professional stature as to justify the confidence placed in the organized profession by the executive and law making bodies of the State.

The County Medical Society Compensation Com mittees have a definite advantage over the Medical Practice Committee which is composed of only three Practice Committee when a complexe to only three members. The Society Committees have set up specialist advisor; subcommittees to qualify specialists which obviously could not be done by a Medical Practice Committee. We, therefore urgs the abolition of the Medical Practice Committee and the restoration of functions to the Workmen's Compensations Committees in the countries of the Society of th sation Committees in the counties of one million and more population. Over a period of nearly eleven years there has been a gradual improvement in procedure so that the recommendations of county medical society workmen's compensation committees may be looked upon as authoritative

I move the adoption of this portion of the report The motion was seconded, and as there was no discussion, it was put to a vote, and was unani-

mously carried

DR HOLCOMB (M-17, Thoracic Surgery) In 1942 your committee, after approval by the Council, recommended to the Department of Labor that the symbol M-17, which previously had been a catch-all for unrelated specialties, be abolished, and that M-17 be utilized for the specialty of thoracic sur-Under date of March 30, 1942, Mr Ralph R Boyer, director of the Division of Workmen's Compensation of the Department of Labor approved the use of this symbol for thoracic surgery

The present Chairman of the Workmen's Compensation Board, Miss Mary Donlon, has recently raised the question as to the validity of this symbol. A determined effort is being made to induce the Chairman of the Workmen's Compensation Board to confirm the use of this symbol for thoracic surgery

We recommend that the symbol M-17 be granted to physicians who possess the necessary qualifica-

tions established for this specialty

I move the adoption of this portion of the report

The motion was seconded, and as there was no discussion, it was put to a vote, and was unani-

mously carried

Dr. Holcomb As a result of the Condon Bill. Senate Introductory 1708, the Workmen's Compensation Law has been amended giving to the Chairman of the Workmen's Compensation Board authority to review the qualifications of physicians upon the recommendation of the Medical Practice Committee or of the Workmen's Compensation Committees of the Medical Societies outside the metropolitan area The Chairman may on such advisory recommendation review and after reasonable investigation revise the rating given to a If the physician is dissatisfied with the physician change he may appeal to the Medical Appeals Unit of the Industrial Council It is the opinion of your Reference Committee that before a county society or the Medical Practice Committee makes a recommendation to change a physician's rating, he be given an opportunity to appear before the Committee and defend his position. The law, as amended, does not provide for such initial hearing original hearing is advisable because even though the physician has a right of appeal to the Medical Appeals Unit of the Industrial Council, the decision of such Medical Appeals Unit is only advisory to the Chairman of the Workmen's Compensation Board Thus, a physician may be in a position where his rating was changed after investigation of the Chairman of the Board and even though the Medical Appeals Unit agreed with the physician in his position, the Chairman of the Workmen's Compensation Board might ignore the findings of such Medical Appeals Unit and maintain her original position. We, therefore, recommend that a hearing be vouchsafed every physician before a recommendation is made that his rating be changed
I move the adoption of this portion of the re-

port

SPEAKER ANDRESEN Is there any discussion? Dr. Thomas M D'Angelo, Queens I would like to ask whether or not the county society has the same privilege If the rating is increased can the county society then come back and ask for a hearing of their side?

DR HOLCOMB That is the intent, that the physician be heard before his county society or before the Medical Practice Committee before his rating is changed Our feeling is that he is entitled to a hear-

The motion was seconded, and as there was no further discussion, the motion was put to a vote.

and was unanimously carried.

DR HOLCOMB In conclusion, your Reference Committee wishes to call to the attention of the Medical Society the tremendous amount of time and unselfish effort which the Council Committee, composed of Drs Dattelbaum, Mellen, and Henry, has contributed to this very vital work

We also particularly desire to commend Dr. David Kaliski, Director of the Bureau of Workmen's Compensation of the State Medical Society, for his wise and able direction and comprehensive knowl-

edge of his duties

I move the adoption of this portion of the report The motion was seconded, and as there was no discussion, was put to a vote, and was unanimously carried

DR HOLCOMB I move the adoption of the report

as a whole, as amended

The motion was seconded, and as there was no discussion, was put to a vote, and was unani-

mously carried

DR. MAURICE J DATTELBAUM Since we are aving out so much thanks for the work done by the State Society and the Committee of the Council, I believe we owe a vote of thanks also to Miss Donlon for her cooperation, her tactfulness in the handling of such a serious question so ably, and also a vote of thanks to Dr Van Etten and his committee for enabling us to get this increase You have no idea how much time they have put into this whole problem I move that

DR ABRAHAM KOPLOWITZ I second that SPEAKER ANDRESEN I don't believe we need to refer that to a reference committee

CHORUS No, let us act on it now

The question was called, and the motion was put to a vote, and was unanimously carried

Section 127 (See 49) .

Report of Reference Committee on New Business B Conditions Governing the Relationships Between the Hospitals and the Specialists of Laboratory Medicine in the State

W WILLIAMS, Bronx There have been two resolutions referred to the Reference Committee

on New Business B

On the resolution introduced by Dr Stephen Curtis, of Rensselaer County, on "Conditions Governing the Relationships Between the Hospitals and the Specialists of Laboratory Medicine in the " reading

State," reading
"WHEREAS, it has been established by the American Medical Association that the practice of pathology is the practice of medicine, and

"WHEREAS, many of the recent advances in the field of medicine are directly attributable to the contribution of the workers in the field of laboratory research and the practical applications thereof in the field of clinical medicine, and

"WHEREAS, the practitioner of medicine welcomes and utilizes fully the scientific help supplied by these practitioners of laboratory medicine, and

"WHEREAS, in the hospitals of this country there now exists an intolerable situation by which the natural expansion of laboratory medicine is

being retarded
(a) Through the improper and arbitrary con trol of the scientific and administrative efforts of this group of medical practitioners and

(b) By the extensive economic exploitation by the institutions of the scientific efforts of

this group, and "WHEREAS it is the feeling that the present existing situation will diminish the number of younger men entering the ranks of this specialty thus seriously deploting a growing and increasingly

useful branch of medical practice, now be it

Resolved that the House of Delegates of the
Medical Society of the State of New York give cognizance to the existing situation and be it

further

Resolved, that the situation be carefully studied by the Society with the avowed purpose of developing a new pattern of practice of the specialty of laboratory medicine in the hospitals placing such practice on the same broad basis as now governs the relationship of medical specialists with the institutions of this State, and that a committee be appointed by the President with the approval of the Council to carry out this study,

which resolution was introduced at the request of the New York State Society of Pathologists your Refer ence Committee has considered this resolution, and after deliberation recommends that, in full realiza-tion of the fact that the problem of the laboratory men and their relation to the hospital has been presented to this House in many varied aspects in several resolutions over the years this resolution be approved in principle and that it be referred to the Council for action.

I move the acceptance of this recommendation.

The motion was seconded and as there was no discussion, it was put to a vote and was unanimously carried.

Section 128 (See 88)

Report of Reference Committee on New Business B Medical Economics in Medical Schools

DR. FREDERICK W WILLIAMS, Bronz. Regarding the resolution introduced by Dr. William B. Rawls, of New York County on the subject of Medical Economies in Medical Schools

WHEREAS, the training of medical students is to a great extent under the direction of full-time teachers who are not and in many instances were nover, engaged in the practice of medicine and, therefore are frequently not acquainted with or not in sympathy with the viewpoint of the practitioner of medicine on socio-economic problems

WHEREAS, at a previous meeting of the House of Delegates of the American Medical Association it was requested by the House that courses in economics be established in medical schools as soon as feasible and

WHEREAS such a program was delayed by the

onset of war therefore, be it

Resolved, that the American Medical Associa tion, through proper channels, take active steps to insure the presentation to all medical atudents in the United States of the viewpoint of the practitioner of medicine on socio-economic problems and be it further

Resolved that the American Medical Associa

tion assist in the preparation of the material, the securing of speakers or in any way that is deemed necessary to further the institution of such a program at the earliest possible date

after consideration of this resolution your Reference Committee recommends its adoption I so move

Dr. Alfred M. Hellman, New York I second the motion.

SPEAKER ANDRESEN Is there any discussion?
DR. HARRY ARANOW (Councilor) We cannot resolve what the American Medical Association can We can resolve to recommend to the American Medical Association but we cannot resolve what they shall do

Speaker Andresen Will you change the wording

of that to meet that objection?

DR. WILLIAMS Yes we would be glad to accept the amendment in the resolved clauses to read

"Resolved that we recommend that the American Medical Association, through proper chan nels etc. and

Resolved, that we recommend that the Ameri can Medical Association assist in the preparation of the material, etc.

The question was called, and the motion was put to a vote and was unanimously carried.

Section 129 (Sec 23)

Report of Reference Committee on Report of Council-Part IX Basic Science Law

Dr. Andrew A Edoston, Westchester This is a resolution that was introduced by Dr. Charles Gullo of Livingston County in regard to the Basic Science Law

WHEREAS, the intent of the resolution of Dr. George Cottis made before this House of Delegates in October 1945 was that an abstract be printed of the essential points of the Basic Science Law, showing where it has worked and where it has not worked, why it has not worked, and whether the American Medical Association is wrong when it goes to the trouble of preparing a model act for us to follow, and "WHEREAS, the Medical Practice Committee in

its present report does not contain certain factual material necessary for its members to arrive at a proper decision as to the desirability for an ideal Basic Science Law for New York State as a safeguard to prevent the licensing of cults and at the same time serve to implement the Medical Practice Act in order to prevent the circumvention of the Medical Practice Act therefore be it

Resolved that there be a full discussion on the floor in executive session with the House of Delegates serving as a Committee of the Whole and that each county be given the opportunity to ex press some opinion upon this question,

After many years of consideration of the Basic Science Law by previous Houses of Delegates legislative and reference committees, supplemented by the exhaustive study of your Medical Practice Committee and in addition the action of the present House of Delegates in disapproving the Basic Science Law your Reference Committee recommends disapproval of this resolution.

I so move

The motion was seconded and as there was no discussion it was put to a vote and was car ried

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Section 130 (See 28, 95)

Report of Reference Committee on Report of Council-Part XI Establishment of Organization Section in the New York State Journal of Medicine

Dr. Eugene H Coon, Nassau I wish to report on the Bronx County resolution that was referred back to the Reference Committee of Report of the Council Part XI regarding certain changes of the JOURNAL

"WHEREAS, sound functioning of a democratic organization is dependent upon an informed

electorate, and

"WHEREAS, our New York State Medical Society, especially the House of Delegates, is such a democratic organization, and

"WHEREAS, the Council acts for the State Society between sessions of the House of Delegates,

and

"WHEREAS, it is the custom to publish the reports of the Officers, Council, and Standing Committees in the April 1 and April 15 editions of the NEW YORK STATE JOURNAL OF MEDICINE JUST preceding the annual meeting of the House of Delegates, and

"Whereas, this custom allows insufficient time for study and deliberation by the representative county societies to enable them to instruct their

delegates, therefore, be it

"Resolved, that the House of Delegates of the Medical Society of the State of New York direct the Publications Committee to establish an Organization Section in the New York State JOURNAL OF MEDICINE similar to that of the Journal of the American Medical Association, and be it further

"Resolved, that there shall be published in this section all minutes of Council meetings, progress reports of all standing and special committees, and any additional information which the Council may direct"

Your Reference Committee agrees in principle with these parts of the resolution However, the Committee feels that there may well be certain items incorporated in the minutes of Council meetings which should not be published and, therefore, become public information, hence we recommend that only such portions of minutes of the Council meetings as the Council may direct be published in the JOURNAL, together with progress reports of both standing and special committees and any additional information which the Council may direct

I move the adoption of this portion of the report The motion was seconded, and as there was

no discussion, it was put to a vote, and was unanimously carried

DR COON Continuing with the same resolution

"Further Resolved, that the annual reports be published in the March 15 and April I issues of the NEW YORK STATE JOURNAL OF MEDICINE '

Your Reference Committee is in sympathy with the spirit of this part of the resolution These reports should be published to reach the membership After consultation with our Secretary, Dr Anderton, and the Editorial Board of the JOURNAL, we find that the failure of the Council Committee Chairmen to file reports before the March 1 deadline causes the delay in publication. We recommend that the President urge all Council chairmen to be more prompt in filing their reports

I move the adoption of this portion of the report The motion was seconded, and as there was no discussion, it was put to a vote, and was unanimously carried

Dr Coon I now move for the adoption of the

report as a whole

The motion was seconded, and as there was no discussion, it was put to a vote, and was unanimously carried

Section 131

Report of Reference Committee on Report of Council-Part III School and Industrial Health

DR JOHN T DONOVAN, Erie The Study Committee on Industrial Health held a meeting in New York City on November 13, 1946, to discuss the educational program Present at this conference were members of the Council Committee on Public Health and Education, and some of the officers of the Medical Society of the State of New York

Many of the lectures arranged by the Committee on Public Health and Education for County Medical Societies are a part of the Industrial Health Program

even though not so designated

In view of the fact that industrial health and school health are becoming a much larger field in medicine each day, that there are many physicians taking up industrial health, and that it is recognized as a branch of medicine which is doing worthwhile work in the medical field, your Committee believes that more attention should be paid to these fields of industrial health and school health, and that men in those fields be encouraged to bring their problems in closer relation with the Medical Society of the State of New York.

The Committee also believes that there should be a division of the various subjects relating to industrial health and school health, brought out independently of the Public Health and Education Com-

mittee

I move the adoption of the report

The motion was seconded, and as there was no discussion, it was put to a vote, and was unanimously carried

Section 132 (See 81)

Report of Reference Committee on Report of Council—Part VIII Veterans Medical Service Plan of New York, Inc.

DR LEO E GIBSON, Onondaga This is the report of the Reference Commuttee on Report of the Council, Part VIII, on the resolution introduced by Dr Herbert H Bauckus, Past-President, concerning Veterans Medical Service Plan of New York, Inc.

"WHEREAS, the veteran suffering from injury or disease incurred during service in the armed forces deserves not only great sympathy from the com-

munity but medical care second to none, and "Whereas, the State of New York through its workmen's compensation commission provides the highest type of care for its injured workers,

and
"Whereas, veterans with service-connected disabilities should receive medical care of the same high quality as is now being rendered under Veterans Medical Service Plan of New York, Inc. and

"WHEREAS, the majority of patients in veterans hospitals are those with nonservice-connected disabilities and the Veterans Administration contemplates the erection of enormously increased facilities, primarily to take care of veterans' nonservice-connected disabilities, and

"Whereas, it would be false economy to deprive the voterans with service-connected disa bilities of the finest medical care therefore be it

Resolved, that the Medical Society of the State of New York importune the President of the United States and the Administration of Voterans Affairs to continue and augment the present "home town medical care program and be it further

"Resolved, that the delegates from the Medical Society of the State of New York are hereby in structed to present a resolution to the House of Delegates of the American Medical Association urging the same consideration for the veterans of the entire United States

This resolution is approved as presented and I move its adoption

The motion was seconded and as there was no discussion, it was put to a vote, and was unani mounly carried.

Section 133 (See 82)

Report of Reference Committee on Report of Council—Part VIII Veterans Care in Civilian Hospitals

Dr. Leo E. Gibson, Onondaga. On the resolution introduced by Dr Benjamin M Bernstein of Kings subject 'Veterans Care in Civilian Hospitals

"Whereas, the present practice permits any physician practicing in the State of New York to care for a veteran for a service-connected condition

at home or office and
WHEREAS, the present practice except in
isolated instances, does not permit the physician caring for this voteran to extend such care to a civilian hospital thus interfering with the continuity of care given to the veteran by his physi-

cian, be it
Resolved that the Veterans Administration be as to permit the continuous care of the veteran by the physician of his choice, either at the veteran's home, at the doctors office, or in any civillan hospital in which the physician usually cares for his own private patients

This resolution is approved by your Reference Committee

I move its adoption.

The motion was seconded, and as there was no discussion it was put to a vote and was unant

mously carried SPEAKER ANDRESEN Are there any other com-

mittee reports? There was no response.

SPEAKER ANDRESEN Are there any other committee reports or any more motions?

There was no response

SPEAKER ANDRESEN Are there any more resolu tions?

There was no response.

SPEAKER ANDRESEN This is your last opportunity to introduce any resolutions. No resolutions can be introduced tomorrow

There was no response.

Speaker Andresen If not I have a couple of notices

Section 134

Notice by Dr James F Rooney of Intention to Introduce General Amendments to Bylaws

SPEAKER ANDRESEN Dr Rooney gives notice that he proposes to introduce general amendments to the bylaws at the next meeting of the Society gives him an opportunity to get them published a month before the next meeting to make it legal

Section 135 Appouncements

SPEAKER ANDRESEN I want to speak about the exhibits As you know the technical exhibitors con tribute a great deal to the cost of this meeting. It is desired to have as many people go down and look at the chilbits as possible so whenever you have the chance to go down and look them over please do so The other thing is that Mr Anderson is very

anxious to have you buy your tickets for the ban quet for tomorrow night if you are going to be here because he has to let the hotel know tonight

how many to arrange for

If there is no other business we will recess until 9 o clock tomorrow morning, when the first business will be the Election of Officers

The session recessed at 6 05 P M.

### Morning Session Wednesday, May 7 1947

The session convened at 9 50 A.M.

SPEAKER ANDRESEN The House will be in order I have a couple of announcements to make first is that the newly elected Council which we are going to elect today will meet immediately after this session, and the Board of Trustees will meet immediately after that,

Also I would like to announce again about the banquet for tonight at which they are going to honor the men who have been fifty years in the Society The dinner is to be informal but you may wear evening dress if you like. We would like to have you buy your tickets some time early this morning.

#### Section 136

Appointment of Planning Committee for Medical Policies

SPEAKER ANDRESEN Also I would like to an nounce that the Speaker wishes to reappoint the Planning Committee that served us so well last year That includes the five officers and Dr Kenney

We will listen later this morning to the announce-ment of the Awards Committee They are not quite ready to report on the awards for the exhibits

### Section 137

#### Flections

SPEAKER ANDRESEN The first order of business this morning is the election of officers. We want to inquire first whether we have a quorum

Mr Secretary how many are present? SECRETARY ANDERTON The number has not been counted but there are more than the required number for a quorum.

SPEAKER ANDRESEN A quorum is present.

We now come to the nominations. Before we go into these however I want to announce that we have a long list of tellers

Joseph A Landy Frank LaGattuta Thomas McCarthy John L O Brien Frederick W Williams Frederick A Wurzbach, Jr

Charles L Pope

Charles E Goodell

#### APPOINTMENT OF TELLERS

Charles F McCarty Chairman Kings
Everett C Jessup, Second District
Harold Kelly Anesthesia
Halford Hallock, Orthopedics
Claude Nuckols Albany
Edward Flood, Bronx
Frank LaGattuta, Bronx
Eiton Dickson, Brooms
John Edwards, Columbia
A H Aaron, Erie
Harry Guess, Erie
Joseph Geis, Essex
Peter Di Natale Geneses
Leo Drexier, Kings Joseph Geis, Essex
Peter Di, Natale Geneses
Leo Drexier, Kings
Irving Sands, Kings
Irving Sands, Kings
Felix Ottaviano Madison
Joseph Henry Monroe
Eugene Coon, Nassau
Horace Ayers New York
Samuel Burk, New York
Guy Philbrick, Niagara
John F Kelley Oncida
Dwight Needham, Onondaga
J E Noll Orange
Arthur Fischl Queens
Vincent Juster, Queens
Kenneth Creevy, Rensselaer
Frank Tellefsen, Richmond
Armand Scala, Rockland
Joseph Cornell Schenectady
John Sengstnck, Suffolk
Harry Golembe, Sullivan
Morris Maslon, Warren
Andrew Eggston, Westchester
Reginnld Higgons Westchester

#### NOMINATIONS AND ROLL CALL

Nominations were received Assistant Secretary Dr Frey read the following list of those who were entitled to vote

Officers, Councilors and Trustees

OFFICERS, C
Louis H Bauer
Edward R Cunnifie
Charles D Post
W P Anderton
W Guernsey Frey, Jr
James R Reuling
Fenwick Beekman
Albert F R Andresen
James F Rooney
Floyd Winslow
I Stanley Kenney Harry Aranow
O W H Mitchell
Maurice J Dattelbaum
Dan Mellen
Carlton E Wertz Christopher Wood Charles M Aliaben Albert A Gartner William H Ross John J Masterson J Stanley Kenney

Ex-PRESIDENTS

Charles Gordon Heyd Arthur J Bedell Frederic E Sondern Samuel J Kopetzky George W Cottis Thomas A McGoldrick Herbert H Bauckus Allen A Jones Martin B Tinker Thomas H Halated Arthur W Booth Orrin Sage Wightman Nathan B Van Etten Harry R Trick William D Johnson

DISTRICT DELEGATES

Scott Lord Smith Everett C Jessup John L Edwards Frank F Finney H Dan Vickers Ivan N Peterson Lloyd F Allen William J Orr

SECTION DELEGATES

Halford Hallock
Stephen H Curtis
Joseph P Garen
Frederick E Elliott
Beverly C Smith
Francis P Twinem Harold C Kelley Clarence H Peachey H E Reynolds Russell C Kimbali Russell C Kimbali Jefferson Browder Irving W Potter Harold H Joy

#### COUNTY SOCIETY DELEGATES

Raymond F Kircher Claude C Nuckols Jr

Allegany (1)

Donald D Prentice

Bronx (15) J Lewis Amster Renato J Azzari Edward P Flood Goodlatte B Gilmore Samuel Gitlow William Klein Moses H Krakow Brooms (3)

Victor W Bergstrom Elton R Dickson

Cattaraugus (1) Leo E Reiman Cayuga (1)

Alfred K. Bates Chautaugua (2)

Chemung (1) Wm T Boland

Edgar Bieber

Chenango (1) J Mott Crumb

Clinton (1)

Leo F Schiff Columbia (1) John L Edwards

Cortland (1) John E Wattenberg

Delaware (1) Robert Brittain

Dutchess (2) A Leomdoff

Erie (8) A H Anron Harold F R Brown John T Donovan Harry C Guess

Essex (1) Joseph A Geis

Franklin (1) Charles C Trembley

Fulton (1) Sylvester C Clemans

Peter J Di Natale Greene (1)

Generee (1)

Kenneth F Bott Herkimer (1) George H Burgin

Jefferson (1) Charles A Prudhon

Kings (24) Charles A Anderson
Joel F Smith
Ben A Borkow
Benjamin M Bernstein
M E Martin
Leo S Drexler
V Leonard Williams
Thurman B Givan
Abraham Koplowits
Aaron Kottler
Morrie Gless Morris Glass Edwin A Griffin

Lewis (1)

T A Lynch Livingaton (1) Donald Malven

John D Naples J Frederick Painton Porter A Steele Nelson W Strohm

A W Martin Marino Charles F McCarty Donald E McKenna J J Guttman Charles W Mueller William Ostrow Abraham M Rabiner Irving J Sands Solomon Schusahelm Jerome J Greenwald Irwin E Sins Joseph Tenopyr

John L. Senestank

Reginald A Higgons Henry E. McGarvey W Alex Newlands

Madison (1)
Felix Ottaviano

Menree (5) Benedict J Duffy John J Finigan Joseph P Henry

Monigemery (1) P J Fitzgibbons

Assau (5)
Eugene H. Coon
Theodore J. Carphey
John M. Galbraith
Ame York (21)

Acer Fork (#4)
Philip D. Allen
Horses D. Ayers
Clarence G. Bandler
Samula B. Burk
Burtill B. Grohn
Harold R. Davidson
A. Wilbur Durvesa
E. Percy Edies
Georgs W. Fish
Samuel Z. Freedman
B. Wallace Hamilton
Alfred M. Hellman

λίαρεια (#) William A. Peart

Oneida (5) A F Gaffney J F Lelley

Ozendaga (4) Leo E. Gibeon Dwight V Needham

Ontario (1) Homer J Knickerbocker

Orange (5)
Theodore J Proper
J Emerson Noll

Orleans (1) John Dugan Osmego (1) Olin J. Mowry

Otsege (1) Mahlon C Halleck

Painom (1) Henry W Miller Ouesna (18)

Sol Andrad Frank J Cerniglia Thomas M. D Angelo Goodwin A Distler Arthur A. Fischi Joseph D Hallinan

Renaselaer (2) Kenneth Creavy

Rickmond (f) Joseph H. Diamond

Joseph H. Diamond Rechland (f)

Arma Scala

Laurence (I)

Charles F Prairie

Saratega (1)
Joseph L. Kiley
Schenetady (2)
Joseph H. Cornell

Schalarie (1) Donald R. Lyon Charles S Lakeman Leo F Simpson

E. Kenneth Horton Louis A. Van Kleeck

Roy B Henline
Thereas Scanlan
Charles Musicato
Percy Klinganateln
Jere W Lord, Jr
David Lyall
Arthur M Master
Madge O L McGuinness
Peter M Murray
James L Pool
William B Rawis
William C White

Guy 8 Philbrick

Oswald J McKendree

W Walter Street Frederick S. Wetherell

Frederick B. Wetnerell

M Renfrew Bradner

Vincent Juster Henry A. Reisman Francis G. Riley Edward C. Veprovsky Jacob Warne Eara A. Wolfi

Richard P Doody

Frank Tellefson

Alexander N Selman

Charles F Rourke

Schuyler (1) Joseph Y Roberts

Seneca (1) Stanley B Folts Steuben (1) William J Tracy

Sufelh (5)
David Coreoran
Cyril E. Drysdale

Sullison (1) Harry Golembe

Tiega (I) William A. Moulton Tempkins (I)

Norman 8 Moore Ulster (1) Frederick W Holcomb

Warren (I) Morris Maslon Washington (I) Denver M. Vickers

Wayns (1)
Ralph Sheldon
Westchester (6)
George C Adle
Andrew A. Bersto

Andrew A. Eggston Edwin L. Harmon Wysming (1) G. S. Baker

E. O Foster

ELECTION OF OFFICERS, TRUSTEES AND COUNCILORS

The following offiers were elected for one year
President Elect Leo F Simpson, Rochester
Second Vice-President Ralph T B Todd, Tarry-

town
Secretary W P Anderton New York City
Assistant Secretary W Guernsoy Frey Jr, Forest
Hills Gardens

Treasurer James R. Reuling, Bayside Assistant Treasurer Fenwick Beekman, New York

City
Speaker Albert F R. Andresen, Brooklyn
Assistant Speaker, Nelson W Strohm Buffalo
Trustee for Five Years James F Roomey, Albony
Trustee for Four Years Edward R. Cunnifie, Bronx
Councilors Harry Aranow Bronx Floyd S Winslow Rochester J Stanley Kenney New York
City

ELECTION OF A.M.A. DELEGATES

The following were elected 1948-1949 delegates

John J Masterson J Stanley Lenney Thomas A. McGoldrick Harry Aranow Andrew A. Eggston Peter J Di Natale George W Kosmal Stophen Montelth Joseph P Henry and Scott Lord Smith

The following were elected 1948-1949 alternate delegates Thomas M D Angelo, William B Rawls Maurice J Dattelbaum John L. Edwards Leo F Schiff Denver M Vickers, Eugene II Coon John T Donovan Erra A. Wolff and Stephen H. Curtis

#### ELECTION OF RETIRED MEMBERS

The following members were elected to retired membership

ELECTION OF RETIRED MEMBER:

The following members were elected to remembership

Edmund J Barnes, Ossining
John L Bauer Brooklyn
Floyd Pinckney Breese Elmira
William Warren Britt, Tonawanda
Hiram M Buchanan, Watertown
William Caldwell Calhoun, New York City
Pierce J Candee Bufalo
Herbert Richard Charlton, Bronzville
Raymond Clark, Brooklyn
Clayton R Clarke Ransomville
Lewis A. Conner, White Flains
Maurice E Connor, Brooklyn
John A Conway, Hornell
George F Coopernail, Bedford
Robert C Davies, Granzille
Carl F Denman Ithaca
John F Dick, Flushing
Charles B Dugan Beacon
William X oung Finch, Alanhassel
John Russell Foshay, Peekskill
Walter G Frey Forest Hills
Nathantel H viller, Friendshry
Isador C Goldstein Brooklyn
Nathan W Green New Canaan, Connecticut
Charles C Guion New Rochelle
Mark Heiman Syracis
Jacob Heller, Brooklyn
Nathan W Green New Canaan, Connecticut
Charles C Guion New Rochelle
Mark Heiman Syracis
Jacob Heller, Brooklyn
Isador C Guldstein Brooklyn
Rathan Hinz Columbiaville
William Hinz Columbiaville
William Hinz Columbiaville
William Hodge Niegora Falls
H Lyman Hooker New Iork City
Arthur Clarence Jacobson, Brooklyn
David H Jones, Mt Vernon
Tloyd Harding Jones, Elmira
Milton R. Joy, Cazenova
Naximilian L Jutte, New Iork City
Arthur Greene Jacobson, Brooklyn
David H Jones, Mt Vernon
Tloyd Harding Jones, Elmira
Milton R. Joy, Cazenova
Naximilian L Jutte, New Iork City
Frederick L keays Greet Neek
Louis J Laken New Iork City
Frederick L Keays Greet Neek
Louis J Laken New Iork City
Frederick L Rooklyn
James H McCarthy Corona
J Francis Messemer Brooklyn
James H McCarthy Corona
J Francis Messemer Brooklyn
Joseph Day Olin, Walertown
H Arnold Pierce, Fredonia
Harry E Plummer, New Iork City
Charles Pierce, Witerfown
Harry E Plummer, New Iork City
Walter A Shoales Norvich
James S Slavin, Richmond Hill
Mary N Sloan, Buffalo
Herbert L Smith Walertown
William A Shoale, Res Wroth City
Walter A Shoales Norvich
James S Slavin, Richmond
Heller William Lewis Wilson, Nagara Falls
Morrs Worton, Bronz

Drand H Waler Loe-

DR CARLTON E WERTZ (Councilor) Fellow Members of the House, tonight at seven o'clock is the Annual Meeting and Dinner of the Society of the State of New York. Tonight, particularly, the State Society is honoring the men who have been in practice fifty years or more. There are eighty such men who have accepted the invitation

of the Society to be at this meeting. We would like to have as many as possible of the delegates and alternate members of the Society at that dinner The meeting is considered of so much importance that Lase magazine is sending two of its photographers there We hope all of you will try to be present tonight Tickets are available in the rear of the room as you leave

Section 138

Report of Committee on Awards for Scientific Exhibits

One very hardworking Speaker Andresen committee at these annual meetings is the committee that makes the awards for the scientific exhibits These three members have been working very hard for the last couple of days in order to pick out the ones that they consider best I will call on Dr Albert A Gartner, the Chairman of that committee, to report

DR. Albert A Gartner This committee was handicapped by the fact that on Monday the scientific exhibits were not set up. There are so many scientific exhibits, and they are all so good that it is very difficult to judge these exhibits

#### SCIENTIFIC AWARDS

First Prize Dr Siegfried Tannhauser, Buf-The Diagnosis of Malignancy from Histologic Sections of Pleural and Abdominal Fluids, Sputum, and Urine

Second Prize

Drs Kurt Lange, Linn J Boyd, David Weiner, New York Medi-cal College, Flower and Fifth Avenue Hospital, New York City—The Use of Fluorescent to Determine the Adequacy of the Circulation

Honorable Mention Division of Laboratories, New York State Department of Health—Cerebrospinal Application of Newer Knowledge to Medical Practice

#### CLINICAL AWARDS

First Prize Dr Charles LeRoy Steinberg, Rochester—Primary Fibrositis Dr Abner I Weisman, New York-The Gynograph—A New Instrument in the Diagnosis and Second Prize

Treatment of Female Sterility

New York Hospital, Westchester, Division, White Plans-Equipment Aids for Occupational Therapy Honorable Mention

The members of the Committee are Burrill B Crohn, of Manhattan, Dr W W Street, of Syracuse and myself as Chairman.

Section 139

Basic Science Law, Methods to Control Cults

DR JAMES F ROONEY (Trustee) I desire to ask the unanimous consent of the House to present a motion that should have been presented yesterday, but because the idea of making this motion only germinated during last night, and it is rather an important thing in view of the interest the House showed in the presentation of the report of the Reference Committee yesterday on the subject, I will state the nature of the motion. It will be a motion to enable the President to appoint a com mittee as a subcommittee of the Council to study the methods to be applied for the control of cults, this committee to report with its recommendations to this House at the next Annual Meeting That will be the motion and I ask the unanimous consent of the floor to present it

The motion was seconded, and as there was no discussion it was put to a vote and was unani-

mously carried

Dr. Rooner Mr Speaker, I think the stenogra pher has the motion and unless the House wishes me to repeat it I will not take the time to do so I will ask the Speaker to put the motion for whatever · discussion there may be

DR. EDWARD A. GRIFFIN Kings I second the

motion.

SPEAKER ANDRESEN The motion is to have the President appoint a Subcommittee of the Council to study the question of the control of cults and to report at this House a year from now
DR. FREDERICK S WETHERELL, Onondaga

that a Committee to be appointed by the President

from members of this House? DR ROONET YOL

SPEAKER ANDRESEN That committee is to be appointed by the President from members of this House Is there any discussion?

The question was called and the motion was put to a vote, and was unanimously carried

Section 140

Vote of Thanks to Dr. Duncan W. Clark, Chairman of the Scientific Program

DR. A. W MARTIN MARINO Kings The chalr manship of the Scientific Program is a tremendous job A perusal of the program will give you a little idea of the amount of work involved The Chair man for 1917 has spent many hours and days ar ranging this year's splendidly diversified and interesting program. Therefore I move that Dr Duncan W Clark, Chairman of the Scientific Program be given a vote of commendation.

The motion was seconded, and as there was no discussion it was put to a vote and was unant

mously carried.

Section 141

Vote of Thanks to Local Committee on Arrangements

Dr. Flotd S. Winslow (Councilor) Mr Speaker I move that this House of Delegates give a vote of thanks to the delegation from Buffalo and their committee for the arrangements they have made to entertain us as their guests throughout this meeting.

Secretary Anderton I second that.

SPEAKER ANDRESEN The motion is to extend a vote of commendation to the local committee on arrangements for their work. Dr Bauckus wishes to discuss that,

DR. HERBERT H BAUCEUS (Past President) Mr Speaker and Members of the House, were it not for the fact that you are waiting for the report of Tellers I would not take your time with this dis-cussion, but I would like to say that many of us feel very depressed indeed over the kind of weather we have provided for you You may be surprised at this but we do have good days, and if you will come here on the third of July it will be a nice warm day Don't come on the fourth because it always rains then.

I want to apologize for the fact that we have had to meet here in this gloomy dirty dungeon. It is

too bad that we got into this trouble but here we are and of course you have all had to make the bost of it If I have seemed to be cold and preoccupied the last few days it is because of that, and also because I am trying to think of what to say to the city authorities about this I apologize to all of you, and I think we should especially mention the fine receptions that we have had in New York City where so many of the meetings have been held. We tried to make you feel at home here and we arranged for Oklahoma to play across the street. That is about the only thing I think we can claim. We might claim one superiority and that is we don't have any smallpox in Buffalo at least I don't think we do Nevertheless we hope that you will forgive these things that we really could not help and that you will forget about them and be happy to come with us again because we do enjoy seeing all of you and helping to do something for the Medical Society of the State of New York.

The question was called and the motion was put to a vote, and was unanimously carried.

SPEAKER ANDRESEY One thing that Dr Bauckus failed to mention is that they do have an epidemic here of ringworm of the scalp Of course, that is not

as bad as smallpox. (Laughter)

Section 142

Vote of Thanks to Dr J G Fred Hiss, Chairman of Committee on Scientific Exhibits

DR. HOMER J INNICKERBOCKER, Ontario I think we should also give recognition to the work of Dr Fred Hiss, who is Chairman of the Committee on Scientific Exhibits.

DR. JAMES Γ ROONEY (Trustee) I second the motion

There being no discussion it was put to a vote and was unanimously carried.

Section 143

Vote of Thanks to the Speaker

Dil J Stanley Kenney (Councilor) Gentlemen of the House while this bunch of bouquets is being passed out this House would be most remiss if it did not express itself on the record as appreciating the very fine work of our new Speaker He assumed his duties here under very difficult and trying circumstances, and he has done a wonderful job like to have this House express its commendation of his maiden effort

Dr. James F Rooney (Trustes) I arise to second I am also going to reprimand Dr that motion Kenney for trying to steal my thunder but I became engaged in conversation That is my usual motion. I have sat in this House in the time when we had no Speaker when the President of the Society tried to run the House of Delegates, and most of them had one most God-awful time That is how we came to institute the office of Speaker I have seen every Speaker I have sat under them sometimes I have speaker I have sat under them sometimes I have been knocked down by them, but I do want to say this, gentlemen, with all my heart I think that our Speaker today was in a frightfully embarrassing position. We have never had, except for our first Speaker any man elected as Speaker who had not served as Vice-Speaker for at least three years until be got the feel of it. I frankly felt when I made my first statement to the House on Monday, friethfully first statement to the House on Monday frightfully sorry for Dr Andresen. He may not have thought so, but I did. He, furthermore followed by a very brief interim one of the best speakers, and, probably

the best speaker this House ever had, and that is our present President, Dr Bauer It was a hard thing to fill his shoes, but I think every one of us will say That the astounding savoir faire with which from the very first hour on Monday morning this Speaker has developed has been like a new rose in full-time during the first two days of this session, I think it has been a magnificent accomplishment (Applause)

I heard throughout the House two, three, or four times within the last two days, "What did you try to do to Dr Andresen?"

I said, "Make him happy"

Well perhaps I did not be to be

Well, perhaps, I did not succeed, and if I did not I want to apologize now, but I think my good friend knows that what I wanted to do on Monday morning was to wake this House up and get a laugh We got it I hope he will live long, and will flourish, and remain our Speaker until he goes to higher (Applause)

SECRETARY ANDERTON Is there any further discussion of this motion? If not, the Chair will be glad to entertain a rising vote in appreciation for the Speaker's masterful presiding at this meeting

The motion was carried by the delegates

arising and applauding

SPEAKER ANDRESEN I thank you very much, gentlemen, for your well wishes I felt very hesitant when I came here Monday morning I did not know how I was going to make out With your help and your patience with me, we have gotten on, and it has been very much appreciated. I have enjoyed every minute of the meeting I enjoyed Dr Rooney's help, and I certainly appreciate this rising

Are there any other motions? There was no response

#### Section 144

#### Remarks by President-Elect

Speaker Andresen We would like to hear, I think, a few words from our President-Elect

Dr Rooney, will you conduct our President-Elect, Dr Simpson, to the platform

Dr Simpson was conducted to the platform

by Dr James F Rooney amid applause

Dr. Leo F Simpson Ladies and Gentlemen, I am indeed grateful to this House for thinking me worthy of this high honor My capacity to fill this office when my time comes, in a manner worthy of the standards that have been established by the many great men who have headed it, is in the lap of the gods I will, however, before that time comes, have had the benefit of the tutelage of one of the greatest of them all, Dr Louis H Bauer

I know that this is not a one-man job A man in office is constantly surrounded by the ablest coun-That is his hope, and therein lies his strength

I welcome the opportunity to repay in some small measure the debt that I, personally, owe to medicine

Thank you! (Applause)

#### Section 145

#### Remarks by Vice-President

SPEAKER ANDRESEN While we are waiting we would like to hear from our Vice-President, Dr Todd

DR RALPH T B TODD Mr Speaker and Gentlemen of the House of Delegates, I have one face that I am looking at now He told me this might happen to me, and he asked me what I was going to say I said that when I got on my feet my speech disappeared as well as my lap But, seriously, I don't know why I have received this honor I have given some work to the Medical Society both in the County and the State, but I was forced to leave • the ranks of the Council two years ago I was sorry for that because I could see what the Council members were doing for the profession of this State You men who come here each year get their reports, but you can hardly realize just what each member on that Council does for the medical profession of this State and this Country

If I have any remarks at all, it would be to go back home and interest every individual in your various communities to take hold because they do owe, I feel, at least as much as I have given to my profession Let us do that and get the young men interested in the Medical Society so they may give a little of themselves to our profession, which is per-

haps the greatest profession in the world

Thank you! (Applause)

#### Section 146

#### Remarks by Vice-Speaker

SPEAKER ANDRESEN Thank you, Dr Toddl I would like to introduce my new Vice-Speaker, Dr Strohm Next year we will have to give him some work to do

VICE-SPEAKER NELSON W STROHM Mr Speaker and Members of the House of Delegates, during the last few minutes I have been trying to find out just what qualifications I had to have this very distinct honor thrust upon me The only one I can find out is that I live Upstate (Laughter) I hope maybe in the years to come we may find one or two more I do appreciate this honor, and I want to thank you all (Applause)

#### Section 147

#### Vote of Thanks to Board of Tellers

ABRAHAM KOPLOWITZ, Kings I want to move that we express a vote of thanks to Dr McCarty and his Committee of Tellers

The motion was seconded, and as there was no discussion, it was put to a vote, and was unanimously carried

SPEAKER ANDRESEN Is there any further business to come before this House of Delegates

There was no response

SPEAKER ANDRESEN If not, the meeting stands adjourned sine die

(The meeting adjourned at 11 30  $_{\rm A}$   $_{\rm M}$ )

#### NECROLOGY

Hugh Auchincless, M.D., 68 of New York City, died on September 21 A graduate of Yale University in 1901 and the College of Physicians and Surgeons Columbia University in 1905, Dr Auchin closs was consulting surgeon at Vassar Brothers Hospital, Poughkeepsie and New Rochelle Hospital He became attending surgeon at the Vanderbilt Clinic in 1932 and also professor of clinical surgery at Presbytorian Hospital Medical Center becoming During the influenza professor emeritus in 1946 epidemic in 1917 he devised the Auchincless tube used for drainage of the pleural cavity Dr Auchin closs was well known for his surgical work in con nection with cancer of the breast and infection of the hands He was a fellow of the American College of Surgeons and a member of the American Thoracic Surgical Society the State and County medical societies, and the Academy of Medicine Theodorus Bailey, M.D., of New York City died

on September 25 at the age of 72 After graduating from I rinceton University in 1895 and the Colk go of Physicians and Surgeons Columbia University in 1899 he was instructor in diseases of the stomach at Polyclinic Medical School from 1904 to 1908 From 1907 to 1914 he was professor of gastrointestinal diseases at the New York School of Clinical Medi cine He was also medical examiner for the Mutual Benefit the Phoenix Mutual and the Columbian life insurance companies Dr Bailey served as a surgeon during World War I after which he retired from the

active practice of medicine
William S Bainbridge, M D 77 of New York
City, died on September 22 After graduating from the College of Physicians and Surgeons, Columbia University in 1893 Dr Bainbridge held professor ships at several medical schools and was an honorary member of several medical and surgical societies He was the recipient of six honorary degrees from various institutions, the most recent being the degree of Doctor Honoris Causa from the University of San Marcon Peru From 1000 to 1000 he was professor of operative gynecology at New York Post-Craduate Medical School and from 1906 to 1918 professor of surgery at New York Polyclinic Medical School and Hospital. He also had been surgeon at the New York Skin and Cancer Hospital surgical director of New York City Children's Hospital and of Man hattan State Hospital Ward's Island and con sulting surgeon or gynecologist to various hospitals in the New York metropolitan and suburban areas

Dr Bainbridge introduced spinal analgesia to the United States, originated a method of administering oxygen in body cavities and sewing up the cavity with the gas retained for absorption, ploneered in the field of transplanting glands from animals to humans invented a number of surgical instruments and devoloped an improved operating table. He also in troduced a method of starvation lighture and lym phatic block operations for pelvic and abdominal malignancy in order to slow down the growth of cancer and to make it at times amenable to re-

In 1913 Dr Bainbridge aided in forming the Medical Reserve of the United States Navy later being assigned to special duty overseas working with surgeons at frontline hospitals and at convalescent camps in England and France After World War I he voluntarily remained on active duty to practice

He had charge of and teach rehabilitation surgery the surgical department and physical therapy division of the Naval Hospital in Brooklyn made several official medical tours to foreign coun tries, and was one of the first men to give public lectures on cancer With medical officers of the Belgian Army Dr Bainbridge organized the Inter national Congress of Military Medicine and Phar

Milton J Bailin, M.D., of New York City died on September 12 at the age of 73 He was graduated from the Sheffleld Scientific School of Yale Uni versity in 1890 and the College of Physicians and Surgeons Columbia University, in 1900 He also studied in Vienna Dr Ballin had served as chief ear, eye and nose attending physician at Mount Sinai Bronx, and Beth David hospitals. He trans-lated and edited three editions of Polotzer's textbook on the car He was a follow of the Academy of Medicine and of the Academy of Ophthalmology and

Laryngology
Walter Minson Brunet M.D., 60 of Brooklyn died on September 24 He was graduated from the Medical College of the University of Virginia in 1911 and served his internship at Gouverneur and Woman's heapitals New York City. He also studied at Heldelberg Germany. Dr. Brunet Woman's hospitals New York Catudied at Heldelberg Germany served in the Navy during World War I and as medical director at the Bridgeport, Connecticut Brass Company during World War II He was on the courtesy staff of the Woodbury Connecticut Hospital

John R. Comerford M.D of Brooklyn died on September 21 at the age of 51 He was a graduate of the University of Lennsylvania and obtained his medical degree from Baylor University He was a member of the staffs of Texas in 1921 Caledonian and Samaritan hospitals in Brooklyn

Ronald Francis Garvey M.D , 50 of Olean died on August 26 He was graduated from the Uni versity of Buffalo School of Medicine, in 1925 and Interned at the Buffalo General Hospital For the past twenty years Dr Garvey had been associated with Dr J A Wintermantel as a physician and surgeon in Olean. He was attending surgeon at General and St. Francis hospitals, Olean. A past president of the Cattaraugus County Medical Society Dr Garvey was also a member of the American Medical Association and the New York State Medical Society

Rmanuel Giddings, M.D., 61 of Brooklyn died on September 25 A veteran of thirty-six years service in New Yorks municipal hospitals Giddings had been medical superintendent of fings County Hospital for the past ten years He was graduated from New York University, Bellovue Medical School, in 1900 and served his internating at the Emplement New York University and the Confession of the Confessio the Englewood, New Jersey Hospital In 1911 he joined the staff of the Riverside Hospital on North Brother Island, leaving the city service in 1916 to become assistant director of Mount Sinai Hospital He saw service in the Army Medical Corps in the Mexican Border Campaign and in France during World War I Returning to his city hospital career Dr Giddings served successively as medical super intendent of Willard Parker Hospital and Riverside Hospital superintendent of Reconstruction Hos pital assistant general medical superintendent of

#### Medical School Receives Bequest

THE University of Buffalo's Medical School is a chief beneficiary under the will of Mrs S Margaret Berrick Meyer, who died at Lake View on July 28 She was the widow of Dr Edward J Meyer, once president of the Board of Managers of what was then the Buffalo City Hospital and is now the Edward J Meyer Memorial Hospital

The bequest to the University of Buffalo is to be used, according to the will, to construct, maintain and equip a medical school laboratory "for scientific

teaching, and research" The laboratory is to be known as the Edward J Meyer Laboratory "or a similar designation"

If the legacy is sufficient, there will be an endowment fund to defray the expenses of operating and maintaining the laboratory, another endowment, the income of which will be used to pay the salaries of one or more teachers of the school of medicine "whose teaching and research is identified with the laboratory"

#### PERSONALITIES

Retired—Dr E David Friedman, chairman of department of neurology, New York University, College of Medicine, on September 1, after teaching at the college for past thirty-seven years, will continue duties as neuropsychiatrist at Bellevue Hospital psychiatric division and as teacher of graduate neurology at the College of Medicine Dr James H Kellogg, Bemus Point, medical consultant for Chautauqua County welfare department and oldest county employee in point of service, started in 1909 as county home physician, to be succeeded by Dr Harold Saxton, Mayville

Harold Saxton, Mayville
Dr Frederick R. Driesbach, Dansville, one of the oldest practicing physicians in New York State, who served as Livingston County coroner for forty-seven years, and was president of the Dansville General Hospital from its organization in 1927 until his retirement
Dr Sue T Gould, Columbia County Commissioner of Health, effective October 1, who was named acting commissioner in 1942, and appointed to a six-year term in 1946
Dr Bertrand E Roberts, who served as New York State health officer in the Poughkeepsie district for over twenty-

Honored.—Dr George S Allen, Clyde, at testimonial dinner commemorating fifty hears of medical practice, given by Wayne County Medical Society August 12 at Sodus Bay Heights Country Club, was graduated from Buffalo Medical School, 1897, practiced in Clyde since 1900 Dr Joseph I Pascal, New York City, guest lecturer at the Congress of Mexican Society for the Prevention of Blindness, Mexico City, read a paper on "The Spherical Equivalent in Cross-Cylinder Tests" Drs George F Cahill and Meyer M Melicow, of

Columbia University and Squier Urological Clinic, who received a gold medal for their exhibit on "Tumors of the Adrenal Gland" at the convention of the American Medical Association in June at Atlantic City, and first prize for the same exhibit at the meeting of the American Urological Association in July at Buffalo Dr. Herbert R. Edwards, executive director of the New York Tuberculosis and Health Association, who was guest speaker at the fiftieth anniversary ceremonies of the Duham Hospital, Cincinnati, Ohio, on September 19

pital, Cincinnati, Ohio, on September 19
Dr Vincent A. Del Vecchio, Ossining, who has been certified as Fellow of the American College of Anesthesiologists, and is now chief anesthetist at the Ossining Hospital and visiting anesthetist at Sing Sing Prison Hospital Dr Oswald T Avery, of the Rockefeller Institute for Medical Rescarch, New York City, who was awarded one of the annual Lasker Awards for medical achievement, for his studies of the chemical constitutions of bacteria, on

October 9 at the annual meeting of the American Public Health Association, Atlantic City Dr Homer Snith, New York University, who also received a Lasker Award, for his studies on cardiovascular and renal physiology Dr Howard A. Rusk, professor and chairman of the department of rehabilitation and physical medicine at the New York University, College of Medicine, who spoke on "A Community Rehabilitation Program," at St Barnabas Hospital for Chronic Diseases, New York City, on October 16, at a meeting sponsored by the Bronx Council for Social Welfare

Appointed—Dr Murray Bergman, supervising psychiatrist at the Middletown State Hospital, as assistant director of Newark State School, served four years in U S Army, assigned to Hampton Roads Port of Embarkation as consulting neuropsychiatrist, also chief of neuropsychiatric service of Kecoughtan Station Hospital Dr Samuel W Mills, as medical evaminer for Middletown High School, and Dr Anthony Romain as physician for Middletown elementary schools Dr Charles A R Connor, as medical director of the American Heart Association, is now instructor in medicine at New York University, College of Medicine, served in U S Army with Air Surgeon's Office Dr Jerome S Peterson, health officer of the New York City Department of Health, as epidemiologist with the World Health Organization in China, formerly chef medical officer for UNRRA in China, made a study of cholera

Dr David Davis Rutstein, New York City, former medical director of the American Heart Association, as professor of preventive medicine at Harvard Medical School, Cambridge, Massachusetts Dr Anthony B Gedroiz, Saranac Lake, as public health officer of the consolidated health district of Saranac Lake and Harrietstown, to succeed Dr Charles C Trembley Dr Raymond D Fear, Ithaca, as New York State health officer in the Poughkeepsie district Dr Granville W Larimore, New York City, as director of the Office of Public Health Education of the State Health Department, to succeed Burt R. Rickards

partment, to succeed Burt R. Rickards
Elected.—Dr A L Parlow, Rochester, vicepresident of Western New York and Ontario
Urological Society Dr Allen W Holmes, member of Foster-Hatch Medical Group, Penn Yan, to

Board of Trustees of Keuka College
Milestones—Dr Gernt F Blauvelt, Nyack,
celebrated his ninety-eighth birthday August 1,
started practicing medicine in Nyack in 1878, was
instrumental in founding Nyack Hospital, performing first operation on day hospital opened, January
1, 1900, graduated in 1873 from College of Physicians

and Surgeons, interned at Bellevue Hospital, studied abroad two years at University of Strasbourg Dr. Charles E. Lane Poughkeepsic celebrated ninety-second birthday on August 10 has been practicing physician for past sixty four years with office at 280 Mill Street, Poughkeepsic for last fifty-seven

New Offices.—Dr Rogor C Blass, Hudson, now associated with Dr William A. Petry Catakill, practice of obstetines Dr John D Boyd Chittenango in Oneida, for practice of EENT Dr Charles C. Casoy Medina, general practice in Le. Roy Dr Mario L. Cote, formerly on dispensary stall of Post-Graduate Hospittal New York City, in Catakill, practice limited to pediatrics Dr Margaret E. Crusius, in Dobbs Ferry practice of pediatrics Dr Charles V Demong, following completion of surgical followship at Mavo Clinic in Syracuso, for practice of general and thoracic surgery Dr Irving M. Fishman, Jamaies for practice of dermatology Dr Max Fox, in Cato succeding the late Dr Harold G Muller Dr

Angelo A. Franco Hartwick, former public health officer in New Berlin, for general practice.

Officer in New Dermy, to general practice in Troy Dr Albert Grunberg, Valley Stream practice limited to urology Dr Erich Helmann, Valley Stream practice limited to dermatology Dr Arthur D Josephson in Yonkers, for practice of medicine and surgery Dr George J Newman, formerly of Kentucky in Ardsley for practice of medicine and surgery Dr Seymour M Nichter formerly readent, physician at Madison Hospital Madison Tennessee in New Berlin Dr Stewart E. Poterson, general practice in Elmira Dr Dructs L. Sarasson, in Syracuse for practice of general surgery

Dr Charles C Shepard, affiliated with Slocum-Dickson Clinic, Utica, practice of Internal medicine Dr LaVerne Wagner Buffalo general prac-

tice in Dansville.

Armed Services.—Dr Willard Warron, Cooperstown in U.S. Army for two years, as first lieutenant, stationed at San Antonio Texas.

#### COUNTY NEWS

#### Albany County

Dr John J Clemmer vice-president of the Albany County Medical Society and director of the Bender Hygienic Laboratory, spoke on 'The Nocropsy and Its Relation to Medical-Legal Problems at the meeting of the County Society held Soptember 24 at the Albany College of Pharmacy Preceding the program, a business seasion was held at which nine new members were elected.

The first fall meeting of the Woman & Auxhary of the Albany County Medical Society was held on September 24 at the home of Mra. William Burgess Cornell Menanda, Presiding was Mrs. William M. Thomson.

#### Chenango County

Acting on the petition of the Chenango County Medical Society the County Board of Supervisors voted to ask the New York State Health Department to make a survey of the county health needs as ground work for the possible establishment of a county health unit and county laboratory. A commuttee from the Society including Dr John A Hollis, Norwich, Dr Newton Brachin Greene and Dr B L. Dodge, Bainbridge, appeared before the supervisors to explain the request.

#### Clinton County

Postgraduate instruction arranged by the Council Committee on Public Health and Education of the Medical Society of the Stato of New York for the Clinton County Medical Society was held September 25 at the Champiain Nelley Hospital Plattsburg. Dr. Stuart L. Vaughan, assistant professor of medicine at the University of Buffalo School of Medicine presented a lecture on "Management of Blood Disorders.

#### Cortland County

Through cooperation of the Cortland County Medical Society the County Health Department, and the County Tuberculesis and Public Health Committee, free chest x ray examinations of every person, 15 years of age and over, were given at the annual Cortland County Fair held in August.

#### Erie County

Creation of an eight-member County Health Board which officially will begin to function January 1, 1918 has been approved by the Board of Super

visors of Eric County
Dr William H. Handel, county medical drector will be in charge, and the board will include Dr Daniel C Fisher, Clarence Dr Antonio
F Bellanca, Dr Alfred H. Nochren, and Dr
Charles A. Pankow all of Buffalo whose appoint
ments have been approved. In assuming their new
posts, Dr Fisher and Dr Nochren have resigned
from the board of managers of Meyer Memorial
Hospital, Buffalo

#### Greene County

With Brooks Atkinson, correspondent for the New York Times as guest speaker the annual ladies night of the Greene County Modical Society was held in July with a turkey and steak dinner at the Catskill County Club.

Dr Benjamin Miller of Oak Hill presided and

introduced the guest speaker

#### Jefferson County

A lecture on chronic arthritis was given by Dr Charles LeRoy Steinberg, senior visiting physician and physician-in-charge of the Arthritis Clinic, Rochester General Hospital at the meeting of the Jefforson County Medical Society held on September 11 at the Hotel Woodruff Watertown. This post graduate instruction was arranged by the Council Committee on Public Health and Education of the Medical Society of the State of New York for the county group.

The Jefferson County Medical Society is sponsor ing the distribution and service of the Utica Medical and Surgical Plan, which will be offered in conjunction with the Blue Cross Hospital Plan. Dr George S. Nellis Watertown, has been elected to the board of directors of the Plan, which was explained at Juncheou meeting at the Black River Valley Club on September 25 given by the County Society with 200 guests present.

#### Kings County

Sponsored by the Medical Society of Kings County and the Long Island College of Medicine, a fall program of postgraduate courses began in October, under the supervison of the joint committee on postgraduate education, of which Dr William C Meagher is chairman Courses are being held at the Kings County, Beth El, Jewish, Israel Zion, Greenpoint, Cumberland, and Long Island College Hospitals, and are designed primarily for the general

Subjects included are allergy, arthritis, electro-cardiography, diabetes, vascular diseases, clinical therapeutics, hematology, hypertension and nephritis, gastroenterology, diseases of the liver and pancreas, endocrine diseases and disorders, endocrinology, sterility, gynecologic pathology, neurology, pediatrics, prenatal care, proctology, radiology, urology, and v-ray diagnosis.

## Madison County

Medical aspects of the atomic bomb were discussed by Dr Joe W Howland, instructor in medicine at the University of Rochester, School of Medicine and Dentistry, when he spoke to the Madison County Medical Society at its meeting on July 23 at the home of Dr M R. Joy, Cazenovia. Dr Howland was chief of medical research in the medi-

cal division of the Manhattan Engineering District

#### Nassau County

Five Nassau County organizations, including the Nassau County Medical Society, cooperated to sponsor a free chest x-ray service at the annual Nassau County Fair, held in Mineola in September Representing the County Medical Society on the committee was Dr Everett C Jessup

Dr Leo M Taran, director of the St Francis Sanatorium for Cardiac Children at Roslyn, Long Island, spoke on "Rheumatic Fever" at the postgraduate instruction held on September 30 at the Elks' Club, Hempstead, arranged by the Council Committee on Public Health and Education of the Medical Society of the State of New York for the Nassau County Medical Society

#### Niagara County

At the regular monthly meeting of the Medical Society of Niagara County, held on September 9 at Lewiston, Dr John R Paine, professor of surgery at the University of Buffalo, spoke on "Present Status of Cardiac Surgery" A short business meeting followed the presentation of the paper

#### Oswego County

"Pain in and Related to Adult Feet" was the subject of the postgraduate instruction presented by Dr R. Plato Schwartz, associate professor of ortho-pedic surgery at the University of Rochester, School of Medicine and Dentistry, at the meeting of the Oswego County Medical Society held on September 16 at the Cleveland Hotel, Cleveland The instruction was arranged by the Council Committee on Public Health and Education of the Medical Society of the State of New York for the Oswego County Medical Society

#### Queens County

Organized for the advancement of pediatrics, the Queens Pediatric Society has been formed, with plans

for four scientific sessions yearly, it is announced Officers of the new group are Dr Walter C A Steffen, president, Dr Henry A. Reisman, president-elect, Dr Louis Appel, secretary, and Dr Meyeron Coe, treasurer

#### St Lawrence County

Prophesying that "socialized medicine would create a breakdown of the present patient and doctor relationship," Dr William R Carson, Potsdam, spoke at a joint luncheon and meeting of the St. Lawrence County Medical Society and its Woman's Auviliary, held August 21 at the Ogdensburg Country Club, Ogdensburg

#### Schenectady County

Arranged by the Council Committee on Public Health and Education of the Medical Society of the State of New York for the Schenectady County Medical Society, postgraduate instruction was held on October 7 at the Ellis Hospital, Schenectady Feature of the program was a symposium on "Low Back Pain," with Dr John R. Cobb, assistant orthopedic surgeon at the Hospital for Special Surgery, New York City, presenting the orthopedic aspects, and Dr Thomas I Hoen, professor of neurosurgery at the New York Medical College, discussing the neurologic aspects

#### Seneca County

"The Treatment of Fractures by the General Practitioner" was the subject of a lecture by Dr Ruchard S Farr, professor of orthopedic surgery at the Syracuse University, College of Medicine, which was presented at the postgraduate instruction session of the Seneca County Medical Society held on October 16 at the Willard State Hospital, Willard The lecture was arranged by the Council Committee on Public Health and Education of the Medical Society of the State of New York,

#### Steuben County

In conjunction with the Seventh District Branch meeting, the fall meeting of the Steuben County Medical Society was held on September 25 at the Veterans Administration Hospital, Bath. Dr L A. Thomas, president of the County Society, pre-

#### Suffolk County

The medical board of the John T Mather Memorıal Hospital, Port Jefferson, sponsored a symposium on cardiovascular diseases at an all-day meeting at the hospital on August 7, presenting treatment from the medical, surgical, and psychosomatic aspects

Moderator of the symposium, which was approved by the Committee on Postgraduate Medical Educaby the Committee on Postgraduate Medical Education of the Suffolk County Medical Society, was Dr
Louis Faugeres Bishop, Jr, assistant professor of
clinical medicine, New York University Speakers
included Dr A. Wilbur Duryee, associate clinical
professor at Columbia University, Dr Gerald H
Pratt, assistant clinical professor of surgery at
Columbia, and Dr George A. Wolf, instructor of
medicine at Cornell University

Approximately bear made that the Wester

Announcement has been made that the Westhampton Medical Group opened its center in Westhampton in August The members of the group include Dr Leroy B Davis, Dr Seth Ransom Jagger,

and Dr Paul Van Wart Waldo

#### HOSPITAL NEWS

#### Project Underway on Old Age Diseases

NEW York University's College of Medicine and the Goldwater Memorial Hospital, Welfaro Island, New York City are conducting a project in research of old-ago diseases it has been announced by Dr J Murray Steele, associate professor at the College of Medicine and director of the University's Third Medical Division at Goldwater Memorial Hospital.

The program will be carried out at the hospital under the supervision of Dr Steele and a staff of research specialists from the College of Medicine. It will be sponsored by several cooperating agencies, including the City of New York, the National Insti tute of Health of the United States Public Health

Service and the Macy Foundation.

"Herotofore Dr Steele said, "patients with old-age diseases have been available for study only over the short periods of time that they were confined to hospitals. This meant that partial histories and ease records of many individuals are the only ones available for study The averaging out of these figures have provided the only way of arriving at some kind of conclusion about the findings of the diseases studied

However the research project will run along differ ent lines. Patients will be available for research over long periods of time as long as ten to fifteen years. In this way research specialists will be enabled to make a continuous study of old ago diseases as they affect the individual patient giving them the op-portunity to record changes in the diseases and to determine and coordinate cause and effect as reliably as possible

The program marks the first time the facilities of a complete hospital will be available for the study and causes of old age diseases although other insti tutions have carried on similar projects on a partial

basis

Dr Steele said the City of New York has aided the groundwork for the program by making available the use of laboratories and a "main staff" of meetinchers.

#### Hospital Study Now in Progress

A COMPREHENSIVE state-wide program for adequate hospital facilities is now in force with the making of an inventory of existing hospitals by the Hospital Survey and Planning Commission

The Commission headed by Robert T Landsdale State Commissioner of Social Welfare will carry out in New York State the program of the Tederal Hos-pital Survey and Construction Act It is empowered to develop a plan for construction of such public and other nonprofit hospitals as it deems necessary Other members of the commission are Dr Herman E Hilloboe State Commissioner of Health, and Dr. Frederick MacCurdy State Commissioner of Mental

A State Advisory Council to the commission, headed by Lee B Mailler superintendent of the Cornwall Hospital and State Assembly leader has

been appointed by Governor Dewey

#### Cerebral Palsy Hospital to Be Opened in Rochester

THE University of Rochester has signed a contract with the State Health Department for operation of the State s first cerebral palsy research and treat-ment center to be opened this fall in LeRoy

The research and rehabilitation hospital will be operated by the University's School of Medicine and Dentistry and the Strong Memorial Hospital in co-operation with the State Health Department and the National Foundation for Infantile Paralysis.

The State Legislature at its last session appropri-

ated \$150 000 for the LeRoy center and the National Foundation in July 1946 gave the school a program. Mr and Mrs. Ernest L. Woodward, who gave their estate to the Hospital, have provided funds for remodeling the three-story brick house.

The Foundation-sponsored program is under the direction of Dr R. Plato Schwarts associate professor of orthopedic surgery at the University of Rochester School of Medicine.

#### News Notes

Four thousand persons with speech or voice defects were treated last year by the National Hospital for Speech Disorders Dr. James Sonnett Greene the medical director reported recently

Dr Greene, who founded the Hospital thirty years ago said 01 per cent of the patients receive free help. It is estimated that there are over 10 000 000 speech cripples in this country ported. The National Hospital for Speech Dis-orders at 61 Irving Place, New York City is the only medical institution in this country devoted ex clusively to treating them.

The merger of Beth Moses Hospital in the Williamsburg section of Brooklyn and Israel Zion Hospital in the Borough Park section of Brooklyn, was announced July 30 by Norman S. Goets, president of the Federation of Jewish Philanthropies of New The two hospitals will form a single institu tion to be known as the Maimonides Hospital. They will continue to occupy their present quarters

X ray equipment is being provided this fall by the State Health Department to aid in its tuberculosis diagnosing program in up-state hospitals. Accord

ing to Commissioner Herman E Hilleboe, the goal of the lending program is the examination of chests of all general hospital patients, with a view of find-ing unsuspected cases of tuberculosis Because of the limited number of state-owned v-ray units, Dr Hilleboe said that loans of equipment are limited at present to hospitals having 7,000 or more admissions a year

Work was begun in September on the new St Jerome's Hospital in Batavia, which is scheduled for completion late in 1948 Incorporating the latest advances in hospital architecture and equipment, the new fire-proof structure will have a bed capacity of 150, sixty more than is provided by the present building

The success of the Bone Bank of the Hospital for Special Surgery, New York City, was reported by Dr Philip D Wilson, surgeon-in-chief of the hospital, at a meeting of the American College of Surgeons in September Started in 1946, the Bone Bank has been useful especially in grafting for bone defects, such as home switters that Special court contains the started of the surple of the sur fects such as bone cyst, osteitis fibrosa cystica, fibrous dysplasia, and spine fusions.

Appointed.—Dr Frances Greenland, clinical assistant in surgery at Staten Island Hospital and adjunct attending doctor to Memorial Hospital's Strang Cancer Prevention Clinic in New York City, as director of the recently-opened cancer detection center, Staten Island Hospital Dr Warren M Pettingell as chief medical officer of the Veterans Administration hospital at Saratoga Springs, replacing Dr Adrian Gould Dr Stanton K. Livingston as staff doctor in charge of the V\_A hospital As chief of medical services of the Wyoming County Community Hospital, Dr Paul A Burgeson, associated with the hospital for over ten years Dr N M Levine, former director of St Lawrence County Laboratories in Ogdensburg, as resident county Laboratories in Ogdensburg, as resident pathologist in Utica State Hospital, replacing Dr Clarence Russell, who retired July 1 Dr A Benson Cannon succeeding Dr J Gardner Hopkins as professor of dermatology at College of Physicians and Surgeons, Columbia University, after serving as acting director of dermatology service at Presbyterary Respital from 1942 to 1948 ian Hospital from 1942 to 1946

Dr Durwood Smith, resident physician at Thomp-

son Hospital, Canandaigua Dr Joseph S A Miller, former clinical director at Rockland State Hospital, Orangeburg, as medical director of Hill-side Hospital, Bellerose Dr Thomas W Smith, graduate of Harvard University Medical School and former flight surgeon with the US Army Air Forces, as assistant in obstetrics and gynecology, Strong Memorial Hospital, and instructor, Medical School of the University of Rochester To the staff of the US Veterans Hospital at Sunmount, Dr Richard L Woodruff, graduate of the University of Roches-ter, School of Medicine and Dentistry, class of 1940

Dr Howard G Dayman, senior physician since 1940 at Ray Brook State Tuberculosis Hospital, as acting director of the tuberculosis division at Meyer Mem-After thirty-seven onal Hospital, Buffalo months' service as medical officer in the US Army, Dr John V Fernandez, Gloversville, as staff mem-ber at Albany Hospital, Albany

In charge of patients at the University of Rochester's rehabilitation hospital for cerebral palsy children in Le Roy, Dr Federick Zuck, instructor in orthopedic surgery at the University Dr Saul B Meltzer, Elmira, resident in surgery in the Guthrie Clinic at Sayre, as resident in surgery at Mt Sinai Hospital, New York City, beginning July, 1948 As director of the Bureau of Mental Hygiene, Ter-ntory of Hawaii, Dr. John G. Lynn, Scarsdale, who has resigned as chief psychiatrist at Grasslands Hospital, Valhalla Dr Jacques W Maliniac as clinical professor of plastic and reparative surgery and associate attending plastic surgeon, New York Polyclinic Medical School and Hospital, New York

Dr E Jefferson Browder, professor of chincal surgery and clinical professor of neurology, Long Island College of Medicine, as director of surgery, College Division of Kings County Hospital, succeed-ing Dr Robert F Barber, who resigned after eleven

years' service

New officers of Genesee Memorial Hospital, Batavia, staff president, Dr Robert S Jenks, vice-president, Dr Paul J Maloney, secretary-treasurer, Dr Joseph S Diasio Chiefs of service medicine, Dr G Henry Knoll, surgery, Dr Ward B Manchester, obstetrics and gynecology Dr Lawlor F Quinlan, urology, Dr Eugene G Ribby, anesthesia, Dr Frank R Hall, ophthalmology, Dr Robert G Wilson, otorhinolaryngology, Dr Carl C Koester, general practitioners, Dr Sydney L McLouth, roentgenology, Dr Max A Almy, and pathology, Dr Joseph Tannenberg New officers of Genesee Memorial Hospital,

#### BLOOD MONEY

Two Illinois backs were midseason bed neighbors in the charley-horse ward. They tired of reading and the radio, and called for a deck of playing cards The nurse didn't have any
"What's in that little box?" asked one of the im-

patient patients

"Just filing cards," she replied keep tabs on the customers" "We use them to

"Let's have 52 of them," said the patient. "We'll get by"

Poker was played with fervor and a pot got

Real money was piled between the fistfuls of nony cards Came the showdown phony cards

Patient No 1 spread out a full house—3 appendectomies and 2 hernias—and reached for the currency

"Take your hand off the dough," said No 2 "I've got 5 transfusions"—College Coach

#### WOMAN'S AUXILIARY

#### TO THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

#### **COUNTY NEWS**

Chautaugua County The Woman's Auxillary to the Medical Society of Chautauqua County was hostess October't to the wives of physicians attending the meeting of the Eighth District Branch of the State Society in Jamestown Guests of honor were Mrs. Harry F Pohlmann State president and Mrs. William Rennie councilor of the Eighth District The County president Mrs Van S Laughlin, of Westfield, was assisted by Mrs Calvin C Torance, Mrs Harold M Childress, Mrs Ralph L Randell all of Jamestown Mrs Robert Northrup of Westfield Mrs. Edward T Eggert of Orleans County Mrs William G Chapin, of Wyoming County and the following presidents of other Eighth District county auxillaries Mrs. Elmer S Webster Allegany Mrs M G Sheldon Catarangus, Mrs Arthur L Bennott Eric Mrs Paul Welsh Genesee and Mrs James A. O Connor Magara.

Erie County 'Child Care and Health Problems was the subject of the Third Annual Public Health Education Forum, held October 10 in Buffalo by the Medical Society of the County of Erio and its Womans Auxiliary Dr John A Toomey of Cleveland, was the principal speaker A panel of Buffalo pediatriclans answered the questions of the audience Auxiliary members in charge of the meeting were Mrs Arthur L. Bennett Auxiliary president, Mrs John J Maisol, chairman of the Economics and Public Relations Committee hair Lawrence J Radice Public Health Committee chairman Mrs George F Marquis Telephone Committee chair

man, and Mrs Wade B Ellis Press and Publicity chairman

Orange County Members of the Woman's Auxiliary to the Orange County Medical Society including Mrs Harry F Polimann, of Middletown president of the State Auxiliary and Orange County Commander of the American Cancer Society, aided in enecting and manning a cancer exhibit at the Orange County Fair in Middletown in August The exhibit depicted soven danger signals of cancer

Orange County Fair in Middletown in August The chilbit depleted seven danger signals of cancer Nassau County The Medical Economics and Legislation Committee of the Woman 8 Auxillary the Nasau County Medical Society participated recently in a health panel, "To Our Good Health, sponsored by the Womans Forum of Nassau County Mrs P A Robin, a member of the committee, discussed voluntary health insurance one of three topics on the panel

In September the Medical Economics and Legislation Committee presented an exhibit on United Medical Service at the Mincola Fair Committee members were present to explain the Service to the public

Other Auxiliary members worked with the Cancer Committee the Tuberculosis Association, the Mental Hygiene Committee and the Public Health Nursing Council in their display booths at the fair

Council in their display booths at the fair
At the first meeting of the year 1947-1948 a mem
bership tea was held Guests of bonor were Mrs.
Luther H Kiee president-elect of the Woman's
Auxiliary to the AMA and Mrs. Harry F Pohl
mann State Auxiliary president.

## DEPARTMENT OF WORKMEN'S COMPENSATION

CONDUCTED BY DAVID I KALISKI M.D. Director

The New Fee Schedule

THE following interpretation received from the Tassistant counsel of the Workmen's Compensation Board on the new fee schedule which became effective June 1 1947 will be of interest

With regard to the increased medical fee schedule that became effective June 1 1047 the Advisory Committee, in recommending the increased schedule to the Chairman representative as you know of all parties in interest, had in mind that the increased fee should be applicable to those cases in which medical care began on or

after June 1 1947 Where a claimant did not recoivo any medical care before June 1 1947 the increased fee schedule is applicable regardless of date of accident.

In a case where treatment began prior to June 1 1947 and new doctor is called In after June 1 1947 the old fee schedule nevertheless is applicable Compared with the number of in creased fees there cases would be relatively few

DAVID J KALISKI M D

#### CORRESPONDENCE

#### On Theories of Renal Lithiasis

To the Editor

Dr R U Whipple, in his paper, "An Attempt to Unify the Current Theories of Renal Lithiasis," which appeared in the June 15 issue of the Journal, states that the underlying lesion theory is supported by Bermooten's explanation of the rarity of renal calculi in the South African negro by virtue of his simple diet, rich in vitamin A and low in calcium.

I am wondering how he could reconcile the findings of Greta Hammersten who produced kidney stones in animals by a diet low in calcium and magnesium and got rid of the stones by feeding a diet high in both of these elements

The danger in classifications, some sage has said, is that we get to thinking things actually fit into them. Somehow the formation of renal stones does not as yet seem to be amenable to a simple explanation

July 8, 1947 (Signed) ALICE R. BERNHEIM, M D New York Hospital

#### Comment by Dr Whipple

To the Editor

It is pleasing to note my article, "An Attempt to Unify the Current Theories of Renal Lithiasis," has stimulated some thought on the subject. That was my main purpose in writing the paper. I believe, by definition, a theory, which is what I have offered in the article, is a more or less plausible and acceptable principle offered to explain a phenomenon. Only when the proof becomes overwhelming by repeated support of many individual investigators does it approach the realm of a scientific fact.

In preparing this paper I reviewed a considerable amount of the pertinent literature. Unfortunately, I do not recall the paper of Greta Hammersten

quoted by Dr Bernheim To take the opposite side for just a moment, I might say we already know that undue mobilization of calcium, to wit, hyperparathyroidism, can and does cause renal stones in the human

Personally, I should like to see proof by other investigators working independently before using an isolated case as proof incontestable that a particular theory is not supportable

July 20, 1947 (Signed) RALPH U WHIPPLE, M D

21 Roybury Road Rockville Centre, New York

#### **ANNOUNCEMENT**

THE UNIVERSITY OF THE STATE OF NEW YORK THE STATE EDUCATION DEPARTMENT BOARD OF MEDICAL EXAMINERS

Dr W P Anderton, Secretary Medical Society of the State of New York 292 Madison Avenue New York 17, N Y

Dear Doctor Anderton

This is to notify you that the Board of Regents at meeting held June 20, 1947

Voted, That the determination of the Medical Committee on Grievances in the matter of the application for the revocation of the medical license heretofore granted to Jerome H Leadley, Rochester, be accepted and sustained, that, in compliance with the recommendation of said committee, said Jerome H Leadley be censured and reprimanded, that said Jerome H Leadley be ordered to appear for such censure and reprimand before the Board of Regents at a time and place to be determined by the Commissioner of Education, notice of which shall be given to said Jerome H Leadley by said Commissioner, and that the Commissioner of Education be empowered and directed to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote

Dr Leadley is registered for the year 1947 from

447 Genesee Street, Rochester, NY The above order was served on Dr Leadley on June 30, 1947
Sincerely yours.

(Signed) JACOB L LOCHNER, JR, MD, Secretary NY State Board of Medical Examiners July 10, 1947

Dr W P Anderton, Secretary Medical Society of the State of New York 292 Madison Avenue New York 17, N Y Dear Dr Anderton

On November 13, 1940, we notified you that the Board of Regents at their meeting held October 18, 1940, voted that the New York Medical License Number 19804 issued to Aram Kazaz Andounian be annulled and canceled of record

Dr Andounian has applied to the Board of Regents for restoration of his medical license and the Commissioner of Education has ordered that license Number 19804 be restored as of July 21, 1947

Yours sincerely, JACOB L LOCHNER, JR., M D, Secretary N Y State Board of Medical Examiners

July 31, 1947

#### **BOOKS**

Books for review should be sent to the Book Review Department at 1313 Bedford Avenue Brooklyn, N Y Acknowledgmont of receipt will be made in these columns and tended sufficient notification. Selection for review will be based on merit and interact to our readers

#### RECEIVED

A Synopsis of Surgical Anatomy By Alexander Lee McGregor M Ch (Edin) Sixth edition. Duodecimo of 714 pages illustrated Baltimore Williams & Wilkins Company 1946 Cloth \$0.50

Obstetrical Practice By Alfred C Beek M D Fourth edition. Quarto of 906 pages illustrated Baltimore, Williams & Wilkins Company 1047 Cloth \$7 00

The Medical Clinics of North America. Nation wide number March, 1947 Octave Philadel phia, W B Saundars Company, 1947 Published Bimonthly (six numbers a year) Cloth \$10 net Paper \$12 net

Dr Samuel Guthrie, Discoverer of Chloroform, Manufacturer of Percussion Pelleta, Industrial Chemist (1782–1848) By Jesse Randolph Pawl Ing, M D Octavo of 123 pages, illustrated. Water town, N Y Brewster Press 1917 Cloth \$3 50

La Penicilina en Las Vaginitis Gonococcicas Infantiles. By Dr Pedro J Alvares Octavo of 124 pages Caracas Venesuela Agencia Musical 1045

The Management of Tuberculosis in General Hospitals. Patients, Staff, Employees. By the Council on Professional Practice of the American Hospital Association, Robin C Buerki M D Chair man. Octavo of 47 pages Chicago American Hospital Association, 1946 Paper 50c Cloth, \$100

Recent Advances in Clinical Pathology By Various Authors Produced under the Auspices of the European Association of Clinical Pathologists. General Editor 8 C Dyke D M (Ovon) Duodecimo of 468 pages, Illustrated Philadelphia Blakiston Company 1947 Cloth \$5 50

Bone and Bones. Fundamentals of Bone Blology By Joseph P Welnmann, M.D., and Harry Sicher M D Octavo of 464 pages, illustrated St Louis O V Moeby Company 1947 Cloth, \$10

Mental Mischief and Emotional Conflicts. Psychiatry and Psychology in Plain English By William S. Sadler, M.D. Octavo of 399 pages. St Louis O V Mosby Company 1947 Cloth, \$6 00

Bacteriology Laboratory Directions for Pharmacy Students. Compiled by Milan Novak, M D and Esther Meyer, Ph.D. Second edition Quarto of 247 pages. St. Louis, C V Mosby Company 1947 Paper, \$2.75

Probleme Des Selbstmordes. By Fritz Schwarz MD Octavo of 128 pages, illustrated. Bern, Switzerland, Medizinischer Verlag Hans Huber, New York, Grune & Stratton, 1946 Paper 9 80 Sw.Fr

Aging Successfully By George Lawton. Oc tavo of 266 pages New York, Columbia University Press 1946 Cloth, \$2.75

The Pharmacopela of the United States of America (The United States Pharmacopecia) Thirteenth Revision (U S. P XIII) By authority of the United States Pharmacopocial Convention. Prepared by the Committee of Revision and published by the Board of Trustees Octavo of 967 pages illustrated Easton Pa Mack Publishing Company, 1917 Cloth \$8 50

The Medical Clinics of North America New York Number May, 1917 Octavo Philadelphia, W B Saunders Company 1917 Published Bi monthly (six numbers a year) Cloth \$10 net Paper \$12 not

Urology in General Practice By Nolso F Ocker blad, M.D Second edition Octavo of 302 pages illustrated Chicago, Year Book Publishers 1947 Cloth 85 75

Nutritional and Vitamin Therapy in General Practice By Edgar S Gordon M D Third edition Octavo of 410 pages Chicago 1 car Book Publishers 1917 Cloth \$500

Clinical Pediatrics. By I Newton Lugolmass M D Second edition Octavo of 400 pages New York Oxford University Press 1047 Cloth \$4 00 (Oxford Medical Outline Series)

Rehabilitation Through Better Nutrition. University of Cincinanti Studies in Nutrition at the IIIIlman Hospital Birmingham Alabama. By Tom D Spice M D Octavo of 94 pages illustrated Philadolphia, W B Saunders Company 1947.

Recent Progress in Hormone Research. Proceedings of the Laurentian Hormone Conference Edited by Gregory Pincus, Sc.D. Vol. I. Octavo of 309 pages; illustrated New York Academic Press, 1040 Cloth \$7.50

Vitamins and Hormones. Advances in Research and Applications. Edited by Robert S Harris and Konneth V Thimann Vol IV Octavo of 400 pages illustrated. New York, Academic Press 1040 Cloth \$0 50

Tomorrow's Food. The Coming Revolution in Nutrition. By James Rorty and N Philip Norman M D Large duodeclino of 258 pages New York, Prentice-Hall, 1917 Cloth, S3 50

Penicillin Therapy Including Streptomycin, Tyrothricin, and Other Antiblotic Therapy By John A Kolmer Second edition. Octavo of 339 pages, Illustrated. New York, D Appleton-Century Company 1947 Cloth, 86 00

Oxford Loose-Leaf Medicine Supplements. 22 reprints. Octavo New York, Oxford University Press 1947 Available only to subscribers

Physician's Handbook. By John Warkantin M D and Jack D Lange, M.D. Fourth edition. Sextodecimo of 282 pages illustrated Chicago University Medical Publishers 1946 Board, \$1.50

Clinical Allergy A Monograph on the Management and Treatment of Allergic Diseases for General Practitioners and Students of Allergy By Alexander Sterling, M D assisted by Bea Sterling Hollander M.D Octavo of 198 pages illustrated New York International Universities Press 1947 Cloth, \$5.00

Recent Trends in Alcoholism and in Alcohol Consumption. By E. M Jellinek, Sc.D Octavo of 42

pages, illustrated New Haven, Hillhouse Press, 1947 Paper, 50c

Rh Its Relation to Congenital Hemolytic Disease and to Intragroup Transfusion Reactions By Edith L Potter, M D Octavo of 344 pages, illustrated Chicago, Year Book Publishers, 1947 Cloth, \$5 50

What Is Psychology A Basic Survey By Werner Wolff Octavo of 410 pages, illustrated New York, Grune & Stratton, 1947 Cloth, \$400

Adolescent Sterility A Study in the Comparative Physiology of the Infecundity of the Adolescent Organism in Mammals and Man. By M F Ashley Montagu Octavo of 148 pages Springfield, Illinois, Charles C Thomas, 1946 Cloth \$3 50

Essentials of Endocrinology By Arthur Grollman, M D Second edition Octavo of 644 pages, illustrated Philadelphia, J B Lippincott Company, 1947 Cloth, \$10

A Textbook of Pathology By E T Bell, M D Contributors B J Clawson, M D, and J S McCartney, M D Sixth edition Octavo of 910 pages, illustrated Philadelphia, Lea & Febiger, 1947 Cloth, \$10

Gastrits By Rudolf Schindler, M.D. Octavo of 462 pages, illustrated New York, Grune & Stratton, 1947 Cloth, \$10

Peripheral Vascular Diseases (Angiology) By Saul S Samuels, M D Second edition Octavo of 85 pages New York, Oxford University Press, 1947 Cloth, \$2 50 (Oxford Medical Outline Series)

Human Gastric Function An Experimental Study of a Man and His Stomach By Stewart Wolf, MD, and Harold G Wolff, MD Second edition Octavo of 262 pages, illustrated New York, Oxford University Press, 1947 Cloth, \$5.00

Standard Methods of the Division of Laboratories and Research of the New York State Department of Health. By Augustus B Wadsworth, M D Third edition Octavo of 990 pages, illustrated Baltimore, Williams & Wilkins Company, 1947 Cloth, \$10

The Principles and Practice of Medicine Originally Written by William Osler, M D, FRCP Designed for the Use of Practitioners and Students of Medicine By Henry L Christian, M D Sixteenth edition Octavo of 1,539 pages New York, D Appleton-Century Company, 1947 Cloth, \$10

A Manual of the Common Contagious Diseases. By Philip Moen Stimson, M D Fourth edition Duodecimo of 503 pages, illustrated Philadelphia, Lea & Febiger, 1947 Cloth, \$400

Color Atlas of Hematology With Brief Clinical Descriptions of Various Diseases. By Roy R Kracke, M D Octavo of 204 pages, illustrated Philadelphia, J B Lippincott Company, 1947 Cloth, \$500

Surgical Pathology By William Boyd, M D Sixth edition Octavo of 858 pages, illustrated Philadelphia, W B Saunders Company, 1947 Cloth, \$10

Diseases of Metabolism Detailed Methods of Diagnosis and Treatment. A Text for the Practitioner Edited by Garfield G Duncan, MD Twenty-one Contributors Second edition Octavo of 1,045 pages, illustrated Philadelphia, W B Saunders Company, 1947 Cloth, \$12

Diseases of the Chest With Emphasis on X-ray Diagnosis By Eli H Rubin, M D With a Section on "The Principles of Surgical Treatment" By Morris Rubin, M D Quarto of 685 pages, illustrated Philadelphia, W B Saunders Company, 1947 Cloth, \$12

A Textbook of Medicine Edited by Russell L Cecil, M D, with the assistance of Walsh McDermott, M D Associate Editor for Diseases of the Nervous System, Harold G Wolff, M D Seventh edition Quarto of 1,730 pages, illustrated Philadelphia, W B Saunders Company, 1947

Hypnotism Today By Leslie M Lecron, BA, and Jean Bordeau, Ph D Large duodecimo of 278 pages New York, Grune & Stratton, 1947 Cloth, \$4 00

#### REVIEWED

Medical Uses of Soap A Symposium Edited by Morris Fishbein, M D Second Printing with a new chapter on "The Surgical Uses of Soap" Octavo of 195 pages, illustrated Philadelphia, J B Lippincott, 1946 Cloth, \$3 00

This is a Symposium by twelve writers best qualified to discuss the subject. In a book of but 195 pages is contained more real information concerning soap, its manufacture, and its uses in medicine than one might imagine could be found to tell on so simple an article of daily use. In this, the second edition, the editor, Dr. Morris Fishbein, has added a supplementary chapter on its uses in surgery.

#### NATHAN THOMAS BEERS

Endocrine Function of the Hypophysis By Harry B Friedgood, M D Edited by Henry A Christian, M D Octavo of 240 pages, illustrated New York, Oxford University Press, 1946 Cloth, \$4 50 [Reprinted from Oxford Loose-Leaf Medicine]

This book is written by a distinguished research worker in the field of endocrinology. It gives an excellent description of the anatomy and embryology. The biochemistry of the unknown hypophyseal

hormones is portrayed in a stimulating, intensive, and clearly delineated fashion. The clinical syndromes are tersely described and pictured

It is highly recommended to those physicians who are interested in obtaining an excellent conception of the complex pituitary disorders

BERNARD SELIGMAN

Their Mothers' Sons The Psychiatrist Examines an American Problem. By Edward A Strecker, M D Octavo of 220 pages Philadelphia, J B Lippincott, 1946 Cloth, \$2 75

Reasons for the present legion of mental invalids are analyzed in this briskly written interesting volume

"Moms" with their silver cords are taken to task as major factors in the maladjustment of their children "Moms in pants," some of our social institutions which permit "moms" to flourish, and overprotective influences in general are attached

overprotective influences in general are attached Not all the criticism is destructive, advice on child training is given to both teachers and parents

There is much psychiatric wisdom in this volume which will repay any interested reader

ARTHUR J LAPOVSKY [Continued on page 2358]

# NOW

Romansky Formula in FLUID Form



Wyeth fluid penicillin (calcium) in oil and wax—true Romansky Formula—is now available to physicians at all pharmacies Its advantages are important—

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[Continued from page 2356]
The Medical Clinics of North America Philadelphia Number November, 1946 Three-Year Cumulative Index (1944, 1945, 1946) Octavo Philadelphia, W B Saunders Company, 1946 Three-Year Published Bimonthly (six numbers a year) \$16 net, Paper, \$12 net

This issue of the Medical Clinics comprises a symposium of nine articles on cardiovascular diseases, and another of six on clinical pathology Both are good and will add much to the knowledge of the practicing physician Conspicuously excellent are a review of the treatment of coronary disease by Francis Wood, characterized by extraordinary common sense, and a review by Neefe of hepatitis which must surely be the most definitive clinical review of the subject to date

MILTON PLOTZ

Textbook for Psychiatric Attendants By Laura W Fitzsimmons, R.N Octavo of 332 pages, illustrated New York, Macmillan Company, 1947 Cloth, \$3 50

This textbook is clearly and concisely written in simple language. It is set up in outline form and directions can be carried out without difficulty

More illustrations would add to the value of the text, as it is difficult to visualize such procedures as The purpose of the the application of restraints book is well carried out and it should be a valuable textbook for attendants in this field

MARIE M BEHLEN

Principles in Roentgen Study of the Chest. By William Snow, M D Quarto of 414 pages, illustrated Springfield, Illinois, Charles C Thomas, 1946 Cloth, \$10

From the wealth of clinical material observed over many years, the author has selected approximately five hundred films for reproduction and comment Despite the inadequacies of x-ray reproductions, the medical student and the general practitioner can profit greatly by a careful study of the illustrations and a perusal of the accompanying text. In a limited space, the author has compressed much valuable data. For those whose experience has been more extensive, this volume serves well for a rapid review of the roentgenology of the thorax The text is interesting and frequently provocative However, when statements are made regarding the relationship of vitamins to the development of atherosclerosis and cancer, one wonders whether this discussion properly belongs in a volume on roentgen study and interpretation

MILTON R LOUBIA

The Medical Clinics of North America. Boston Number September, 1946 Octavo Philadelphia, W. B Saunders Company, 1946 Published Bi-Cloth, \$16 net, monthly (six numbers a year) Paper, \$12 net

The Medical Clinics of North America, as usual, stresses important clinical material of interest to all practicing physicians Two excellent articles are Cooley's anemia (Ross) and coronary occlusion The latter, particularly, is useful as it helps explode some notions on the usefulness of recent drug therapy Streptomycin is reviewed by Keefer, while Ingelfinger has a fine study on the treatment of infectious hepatitis. There are other good references to lung disorders, laboratory tests, virus diseases, and the use of bilateral femoral vein ligations in thrombophlebitis

ANDREW BABEY

Textbook of Medical Treatment by Various Authors Edited by D M Dunlop, M.D., L S. P. Davidson, M D, and J W McNee, M D Fourth Edition Baltimore, Williams & Wilkins Company, 2 (c 1946) Cloth, \$8 00

The fourth edition of this standard Scottish text maintains the high level of excellence set by its predecessors Although this volume will not supplant its American equivalents, it would be hard to match the uncommon, common sense with which it 35 is written and the exquisite clinical judgment of its contributors

The section on diabetes written by Dunlop is Canaral MacCalman's Psychotherapy in General' Practice also deserves special mention

In short, no one will read this volume without profit, and it is recommended highly

MILTON PLOTZ

Operative Gynecology By Richard W Te Linde, M D Quarto of 751 pages, illustrated. Philadelphia, J B Lippincott, 1946 Cloth, \$18

In line with the author's conviction that the gynecologist must be trained in a comprehensive field, this text includes chapters on the anus and rectum, operative injuries to the ureters, retroperitoneal tumors, surgery of the abdominal wall, particularly hermorrhaphy, appendicitis, and the intestines in

relation to gynecology
The book is well illustrated by 309 line illustrations in black and white, and 15 subjects in full, color on 9 plates The author has been particularly fortunate in procuring illustrations by the famous. medical illustrator, the late Max Broedel, and pupils of his school of medical art. The principal artist is James Didusch, whose illustrations describing various stages in operative procedures are clear and informative

Dr Te Linde's book is a most valuable addition to the texts on operative gynecology and brings the subject up to date It is admirably suited to the needs of residents in gynecology and those who are forced to rely principally on self-instruction for training. The years of experience of the author in one of the foremost gynecologic clinics in the country makes his personal views for the most part authoritative. The text is highly recommended to the profession

ALEXANDER H ROSENTHAL (

The Differential Diagnosis of Jaundice By Leon 3 Schiff, M D Octavo of 313 pages, illustrated. Chicago, Year Book Publishers, 1946 Cloth, \$5.50

This excellent book serves a valuable purpose in integrating the present day concepts, diagnostic measures, and recent advantages in the therapy of jaundice It is complete, well written, and contains a wealth of information The author has performed an excellent service in presenting a subject that is in such a state of transition that there is apt to be some confusion in many minds concerning the best procedures to follow in each individual case 'It should be well received

VICTOR GROVER

Renal Hypertension By Eduardo Braun-Menéndez, Juan Carlos Fasciolo, Luis F Leloir, F et al Translated by Lewis Dexter, M.D. Octavo of 451 pages, illustrated Charles C Thomas, 1946 ( Springfield, Illinois, th, \$6 75 Cloth, \$6 75

This is an extremely good, thorough review of the development of our knowledge of renal hypertension

[Continued on page 2860]

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[Continued from page 2358]

It is written by investigators in Buenos Aires, Argentina, who themselves have done much to elucidate the many problems associated with this disorder. Not only is there information on the development of studies of renin and angiotonin, but a very adequate summary covers advances in medical and surgical management, including the Smithwick operation.

A great number of aspects of this big problem remain to be solved, but a review of this type serves a most useful purpose in focusing our attention in simple fashion on the points which internists ought

to know

ANDREW BABET

Lehrbuch Der Urologie By Dr J Minder Octavo of 348 pages, illustrated Bern, Switzerland, Medizinischer Verlag Hans Huber (New York, Grune & Stratton), 1946 Cloth, 37 50 Sw fr

The fact that the author while writing this book was deprived of the use of his own library and notes explains the absence of any references and bibliography. The various problems are skillfully handled. Their descriptions are conspictions by the fine differential-diagnostic interpretation and short, but pertinent, case histories. Without belittling the diagnostic and therapeutic value of local manipulations and operations on the lower urmary tract, the author emphasizes restraint, unless positive indications request them. The clear presentation makes this book good reading for any student in this line

MAX G BERLINER

Ulcer of the Stomach, Duodenum and Jejunum By Ralph C Brown, M D Edited by Henry A Christian, M D Octavo of 105 pages, illustrated New York, Oxford University Press, 1946 Cloth, \$2.25 (Reprinted from Oxford Loose-Leaf Medicine)

This is an admirably compact monograph on a subject with a tremendous literature. The illustrations and tables are quite clear. The therapeutic emphasis is on the group of seriously ill patients who are logically hospital patients, and the regimen for this group is well documented and soundly based on pathologic physiology.

This little volume is highly recommended

MAURICE TULIN

A Textbook of General Biology By E Grace White, Ph D Third Edition Octavo of 659 pages, illustrated St Louis, C V Mosby Company, 1946 Cloth, \$4 50

This revision, after nine years, maintains the general plan and technic of the previous edition but is brought up to date by including a discussion of the use of results obtained by modern methods of investigation—especially radioactive isotopes

The book is logically and pedagogically sound and presents an interesting selection of topics in addition to the material included in a "standard" course in general biology. The text is clear and interesting, and illustrations are abundant and well chosen.

ARTHUR SHAPIRO

Clinical Hematology By Maxwell M Wintrobe, M D Second Edition Octavo of 802 pages, illustrated Philadelphia, Lea & Febiger, 1946 Cloth, \$11

The second edition of this comprehensive work on hematology meets all the requirements of the medical student, internist, and general practitioner. For completeness and authoritativeness there is no comparable book on hematology. The bibliographies at the end of each chapter are well chosen and make the problem of the reader a pleasant one. The many charts, photographs, and engravings are well done.

MAURICE MORRISON

Manual of Applied Nutrition, The Johns Hopkins Hospital Second Edition Duodecimo of 103 pages, illustrated Baltimore, Dietary Department of Johns Hopkins Hospital, 1946

This is a small pocket sized handbook containing much useful information on diets in therapy. Starting with basic requirements of the various foods, minerals, and vitamins, it goes on to very specialized diets without too much distracting detail or confusing references. It is a handy volume based on sound principles

ANDREW BABEY

Studies in Hypertony and the Prevention of Disease By I Harris, M D, in cooperation with J T Ireland, B Sc, and others Duodecimo of 114 pages, illustrated Baltimore, Williams & Wilkins Company, 1946 Cloth, \$3.00

This monograph consists of observations made on middle-aged normal and hypertensive patients as well as some experimental studies on rabbits. The authors attempt to determine the influence of dietary calcium and cholesterol on the development of hypertension. Also considered are certain relations of potassium, iron, phosphorus, calcium, and sulfur metabolism.

The data are not well presented and the conclusions drawn frequently unjustified. The interpretations of some experiments are little short of extraordinary. The book is not recommended.

DUNCAN W CLARK

Principles and Practice of Obstetrics By Joseph B De Lee, M D, and J P Greenhill, M D Ninth edition Large octavo of 1,011 pages, illustrated Philadelphia, W B Saunders Company, 1947 Cloth, \$10

In this latest edition, Dr Greenhill has brought De Lee's textbook thoroughly up to date. His wide acquaintance with current obstetric literature is constantly evident. Although containing statements to which many obstetricians will take exception, it will serve, in general, as an excellent guide to practitioners as well as a textbook for students. It is copiously and well illustrated. It contains up-to-date and accurate information on chemo- and anti-biotic therapy

J THORNTON WALLACE

Victory Over Pain. A History of Anesthesia. By Victor Robinson, M D Octavo of 338 pages, illustrated New York, Henry Schuman, 1946 Cloth, \$3 50

The history of anesthesia is well depicted in this clearly written and finely illustrated volume. The ever-interesting story of the slow development of anesthesia has been written entertainingly by Dr Robinson, who has explored a large number of source materials in order to render the volume accurate. The sections on Jackson and Morton are historically perfect and the conclusion on curare brings the book up to date

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Size of Articles -It is earnestly desired that scientific articles shall not exceed 6 Journal pages at the outside Longer articles tend to lower reader An average of five or six seems to be the most desirable from this point of view Calculation can readily be made by multiplying the number of double-spaced typewritten manuscript pages by the fraction two-fifths, e g, twelve manuscript pages will make five Journal pages

Manuscripts -- Papers must be typewritten on one side only of white sheets consecutively numbered, and be double spaced with one-inch margins They should be prepared with great care so as to be typographically correct All headings, titles, subtitles, and subheadings should be typed flush with the left-hand margin. This is imperative for rapid and accurate composition by the printers

Titles —The title should be brief and typed in capital letters The subtitle can be longer and should be typed in caps and lower case letters Under the title, or subtitle, if there is one, should appear the name of the author and city in which he lives Directly under his name should be the hospital or institution with which he is affiliated

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Books-author's surname followed by initials title of book, edition, location and name of publisher, year of publication, volume, and page number Thus, Osler, W Modern Medicine, 3rd ed, Philadelphia, Lea & Febiger, 1927, vol. 5, p. 57

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initials, name of periodical, volume, page, month (day if necessary), year of publication Thus, Leahy, Leon J New York State J Med 40 347 (March 1) 1940

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Case Reports -- Instead of abstracts of hospital histories, authors should write these reports in a narrative style with properly completed sentences All unimportant details should be deleted with such general negative statements as fit the case

Tables -- While tables are very useful on lantern slides in the reading of papers, they fail of this pur-pose to a large extent in the printed page For that reason it is urged that they be reduced as much as possible to descriptive language

Illustrations -These should be kept to the minimum necessary to make clear the points to be registered by the author In some instances they are imperative to proper understanding, in others they are merely picturesque. The latter can be excluded to good effect, both as to space and the not inconsiderable cost

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accompany manuscripts and each should always be referred to in the text, preferably by number Drawings or graphs should not be larger than 12 X 16 inches, and must be made with jet black India ink on white paper Do not use typewriter for letter-The smallest lettering on 8 × 10 inch copy should be no less than 1/4 inch high Cross-section paper (white with black lines) may be used, but should not have more than 4 lines per inch If finer ruled paper is used, the major division lines should be drawn in with black ink, omitting the finer In the case of finely ruled paper, only blue-lined paper can be accepted. Lettering and all markings must be large enough to be readable after reduction Mail rolled or flat, never fold Photographs should be very distinct and show clear black and white contrasts They must be on glossy white paper Avoid round and oval photographs

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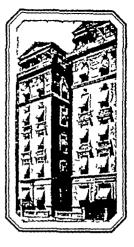
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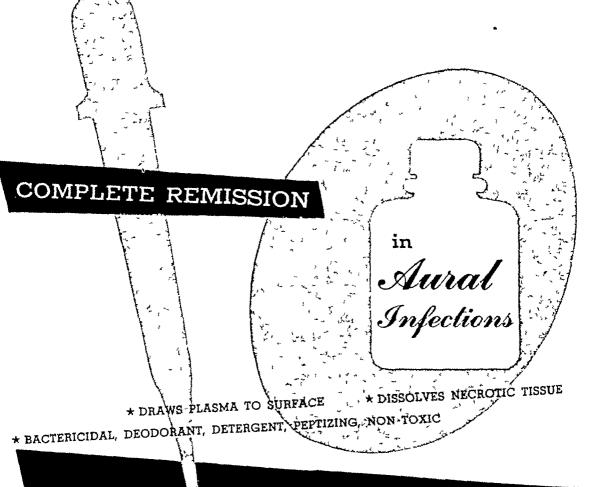
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VOLUME 47

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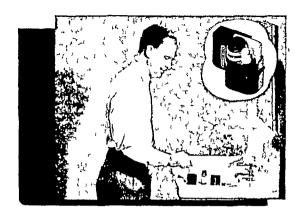
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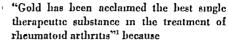
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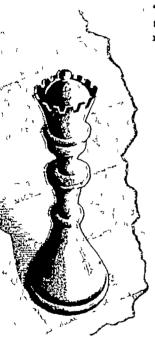
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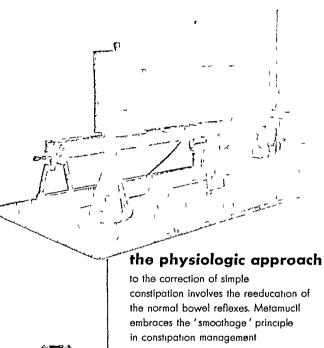
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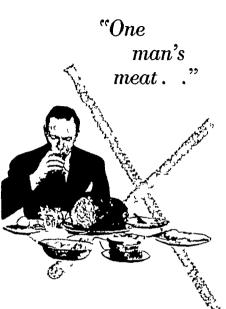
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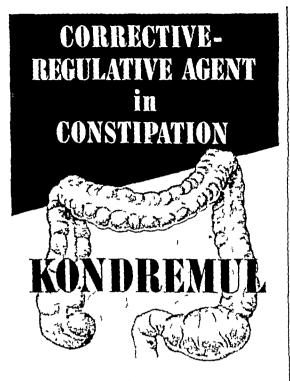
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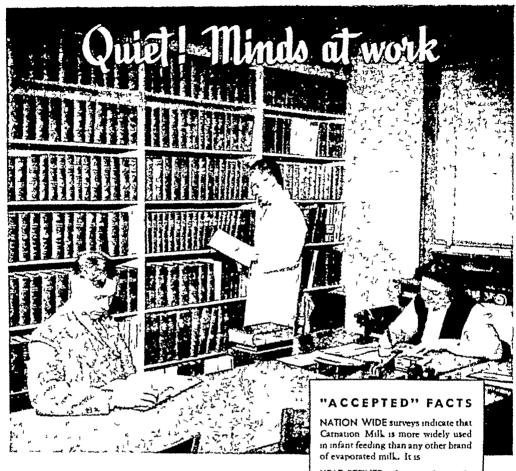
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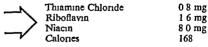
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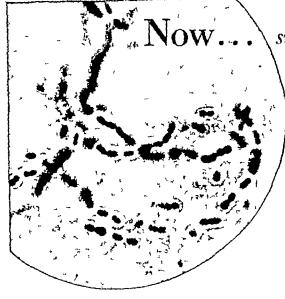
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successful active type-specific
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"The evidence demonstrates clearly that immunization of man with the specific capsular polysaccharides of pneumococcus types I, II, V, and VII is effective in preventing the development of pneumonia due to these types in the immunized subjects" 1

1 MacLeod C. M. Hodges R G, Heddelberger M, and Bornhard W G J Exp Med 82 445 (Dec. 1) 1915

Photomicrograph of DIPLO COCCUS PNFUMONIAF (magnified I 350 times), after 'typing with homologous an tiserum by Neufeld method The swollen unstained sharply outlined capsules contain the type-specific polysacchar ide, which is mixed with similar antigens from other types of pneumococci in the preparation of Solution of Pneumococcus Polysaccharides

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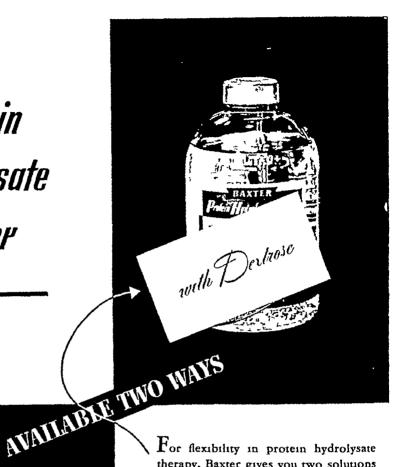
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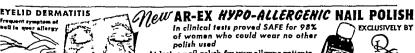
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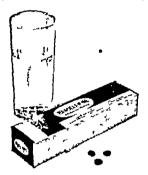
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MCNEIL Filppin, H. F. and Reinhold J. G.: Ann. Int. Mod., 25 433 (Sept.) 1946.

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Socially candy has long been accepted as a pleasant part of our daily lives From early childhood on, candy is considered an appropriate accompaniment of the festive spirit of birthdays, holidays, anniver saries and other joyous occasions

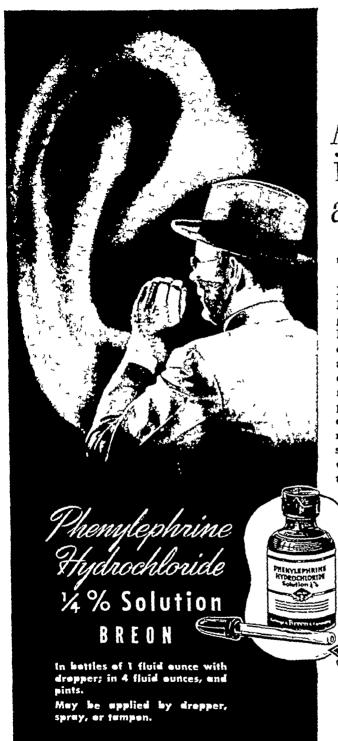
In recent years, with the advancing knowledge of nutrition, the values of candy as a worth while part of the daily diet have also become recognized Most of the kinds of candy manufactured today are made of a number of valuable foods which contribute to the extent they are used to the satisfaction of many nutritional needs \*

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COUNCIL ON CANDY OF THE



<sup>\*</sup>The candies in the manufacture of which milk, butter eggs fruits nuts or peanuts are used, to this extent also (a) provide biologically adequate proteins and fats rich in the un saturated fatty acids (b) present appreciable amounts of the important minerals calcium, phosphorus and iron (c) contribute the macin, and the small amounts of thismine and riboflavin, contained in these ingredients



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> Phenylephrine Hydrochloride-Breon, by clearing the nasal airways, aids sinus drainage in head colds, vasomotor rhinitis, and sinusitis It eases the harassed patient—one of those trifles that-done or neglectedmake a physician liked or-the reverse.

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Warner M. P., J.A.M.A. 115 279 (July 27) 1940.

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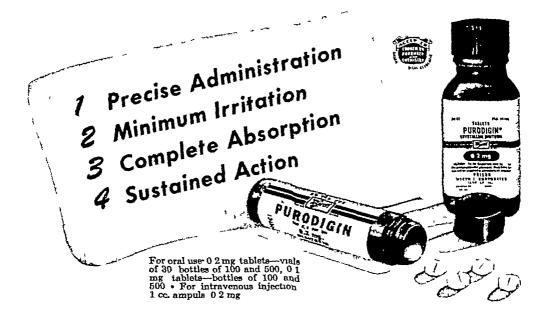
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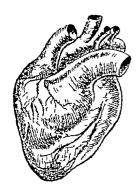
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VOLUME 47

NOVEMBER 15, 1947

NUMBER 22

#### Editorials

#### Plain Talk, I Rising Costs of Medical Service

Is the rising cost of living a threat to the continuation of private enterprise in medicine? All over the world the peoples of the earth have experienced a retrogression in standards of living due to underproduction and rising price levels. Only in the United States has this phenomenon so far been moderate, but acceleration in the process here is even now beginning.

Medical service embraces the cost of professional fees (doctors' and nurses' bills) and, what is more important, the cost of ancillary services (hospital and laboratory, supplies of all kinds, food, coal or oil, transportation, equipment, wages of employees, and the like) Previously we have pointed out that in thinking of medical service it is necessary to segregate professional and ancillary services.

Professional fees are fixed many of them by statute, others by custom and use. The public does not understand this fact, partly because the medical profession does not usually trouble itself to inform people on this point.

Ancillary services, on the other hand, fluctuate in cost and are relatively free to do

so Certain brakes, such as hospital insurance for example, may operate to smooth out violent fluctuations in these costs, certain Federal, state or local subsidies may help also, but on the whole, rising costs of medical service will fluctuate with the costs of the ancillary services

It is important that this be understood. The medical profession, and particularly what is referred to as 'organized medicine,' will undoubtedly be charged in the future, as it has been in the past, by the unthinking, with failure to control the costs of medical service. This will be twisted, for political purposes at least, to mean failure of organized medicine to fulfill its social obligations to the people. Popular magazine writers, political hack writers, assorted nuts of all kinds who can push a pencil for hire will beliabor the subject, on the ground that "they have to live, don't they?"

Of course, the cost of medical service as a whole will follow the trend of the national economy, it will rise as living costs soar Regrettable but true. There is no magic about it, but it will not be because of in-

creased professional fees. This should be brought to public attention by organized medicine. This is not to say that *volume* of professional service will not rise as people demand more service. It will But again, increased *volume* is and will be engendered by public insistence, not by medical professional instigation.

Nearly all the blame for increasing costs for total medical service, therefore, may be laid squarely on the ancillary services where it belongs Control of these ancillary service costs lies in the hands of the public, not in those of organized medicine. But unless this separation of and distinction between professional and ancillary services is made clear to the public, it will continue to regard them as one and the same thing. Medical information services, public relations bureaus of the various state societies, and individual physicians should leave no stone unturned in making this distinction understood.

#### Our Coming Psychiatrists

Apparently, the Surgeon General of the United States Public Health Service proposes, according to the New York Times for July 27, 1947, to devote an appropriation of some \$4,650,000 to the further psychiatric training of social workers

"Candidates must be graduates of an accredited school of social work and must have had at least three years of practice in the profession

"The training units to be started in the various graduate schools conform to a plan now being developed by the United States Public Health Service for a comprehensive nation-wide mental health program under recently enacted health measures"

We shall watch this development in the further training of social workers in the field of psychiatry with much interest, tinged with apprehension

Training of social workers in psychology and psychiatry in order to fit them to aid in a comprehensive, nation-wide mental health program is not without its grave dangers in our view. A social worker who meets the above requirements for preliminary schooling and practice is a more highly educated and more experienced person, but a social worker still

At the present level of training in this field a useful and generally well-balanced individual enters the profession of mass management of human affairs with generally creditable results, as the work of many thousands of workers in departments of public welfare will daily attest

Once upon a time, before it became somewhat overtrained, the same thing could be

said of the nursing profession it nursed, with a sympathetic human understanding of the requirements of sick folks, at the bedside and in the home *Eheu*, fugaces!

Now, with the addition of psychiatric training to the social worker's schooling as proposed, what is likely to be the outcome? If the trainees are to be assistants to the physician psychiatrists in veterans' mental hospitals, working under the direction of the medical profession, that is one thing. Unquestionably, better psychiatric case histories would be advantageous for all concerned, as would more intelligent follow-up of discharged patients.

On the other hand it is already being recognized by writers in the popular journals1 that there is danger in too much emphasis on disease by those not too well qualified to call attention to it trouble is we've scared the living daylights out of people The cancer people keep telling everybody to 'thump that lump' But when we go around telling everybody to take their psychiatric pulses—we are spreading the very disease we are supposed to fight And we've been doing it-with the aid of a lot of amateurs who write books produce movies, and scream over the radio "1

Remember the dancing mania? Remember the Children's Crusade? We do not like to think of ourselves as embarking on a witch hunt, but education in mass psychology may have marvelous results Remember Mussolini? Remember Hitler?

<sup>&#</sup>x27;Maisel, Albert' 'Relax You May Not Be Nuts,'' Collier's Weekly August 16 1947

#### "Madam, Will Your Nose Never End?"

Sir Joshua Reynolds is said to have made the foregoing remark to the famous lady he was painting

We know just how he felt We read this morning in the report of the House of Delegates of the American Medical Association that it had voted to set up a Section on the General Practice of Medicine and, moreover, to establish an examining board to determine the qualifications of diplomates who might be admitted to practice general practice in the wards of our hospitals <sup>1</sup>

We are all in favor of widening the horizon of the general practitioner. We have already said so editorially <sup>2</sup>. We think that, like the Trumpeter Swan, he is a vanishing species, which should be most carefully protected and encouraged to breed. Notice that we did not say "sheltered." Sheltered species do not survive

But examine this latest proposal A medical student studies a fairly carefully standardized course for four years. He then passes his State Board Medical examinations He, then, if he is so fortunate, serves a two years' internship in a hospital approved by the American Medical Association and/or by the American College of Surgeons

He, then, might be supposed to be equipped to practice medicine with a reasonable knowledge of surgery, or surgery with a reasonable knowledge of medicine. If he is wise enough not to decide immediately upon a speciality, he will browse about in the plain business of looking after sick people until such a time as he determines that he wishes to engage in practice of a speciality.

If he does so, then he will be constrained to enter upon an enormously complicated course of further training which will qualify him in his chosen specialty. After he has done that he then will have to submit himself to examination by a Specialty Board This, if he is successful in answering not only their complicated questions, but their requirements as to various residencies, years in practice, etc., will grant him a certificate which proclaims him a diplomate in his

particular specialty If he can have afforded the time and money involved in this process he may then, we presume, go anywhere he likes and engage in lucrative practice in a sphere quite removed from his unlettered—we mean his undiplomated—brethren Of course, in the meantime, he will have passed the tests of the National Board of Examiners This, he thinks, will give him a license to practice anywhere But, no, there are still three states that do not accept the Certificate of the National Board. Pretty pathetic

But now our heart really begins to bleed Suppose he has just been plugging along, looking after sick people, doing the best he could in his small community, earning the respect of his fellow citizens. Perhaps his neighbors say of him, "Maybe Dr Jones don't know so much, but he knows what he knows and he knows what he doesn't know. And he ain't afraid to say so, neither. When my girl got a mastoid he sent me to a man he knew who cured her. That's the kind of a man I want."

We think the judgment of Dr Jones's neighbors is sound But is Dr Jones now to be secure? No If he wishes to be allowed to have his patients admitted to the hospitals of his community he must now qualify as a general practitioner Poor wretch That is what he had thought he had been for many years. His neighbors had been satisfied with his services. He had been fairly satisfied with himself But now the hospital trustees, guided by the omnipotent and omnipresent hands of the A.M.A and the A.C.S, te'l him that if he wishes to practice in their wards he must go far away and take an examination by a Board of what? Gen-That's what he had been eral Practitioners And who are thinking he was all the time the general practitioners who are to examine the general practitioners?

The exact text of the adopted A.M.A resolution reads

The criterion of whether a physician may be a member of a Hospital Staff should not be dependent on certification by the various Specialty Boards or membership in special societies

<sup>&</sup>lt;sup>1</sup> Bull, Am. Coll, Surg. 32: 149 (June) 1947

<sup>2</sup> The Wider Horizon for the General Practitioner New York State J Med. 47: 1479 (July 1) 1947

Mark the masterly use of that most overworked of all words, should Perhaps they shouldn't, but they will be We can see already the cocked eyebrow of the diplomate as he mentions to a trustee the unfortunate parchmentless condition of a rival candidate

And so we go, round and round From examination to examination Farther and farther away from a man's privilege to be judged by his peers, those men of reasonable

common sense with whom he lives and who entrust their wives, their children, and themselves to his medical and surgical judgment. The fact that he has pulled them through many tough spots is not enough. Should Chicago advise the trustees of the hospital in his own home town as to criteria?

And now there is to be a Special Board for the examination of the general practitioner

No wonder Sir Joshua said to Mrs Siddons, "Madam, Will Your Nose Never End?"

#### Fear

We address the remarks that follow to those interested in what we might call the philosophy of education

In our second year in the Medical School anatomy was taught us by a professor of international reputation who was passionately interested in comparative anatomy. He almost cost Oscar of the Waldorf his job, because, when being dined by a wealthy friend, he identified the bones he was spitting out of his mouth as not those of Maryland terrapin, but of squirrels—His accounts of the teleosts being chased out of the primeval slime by the elasmobranchs were fascinating

A student speaker at a medical dinner ventured to criticize him because his lectures were not practical. They taught the future hard-pressed surgeon nothing about where he might lay his fingers upon the inflamed appendix or the obstructed common duct, thereby enabling him to save the life of his patient.

The infuriated professor retorted that he was teaching anatomy for the benefit of the one, or possibly two intelligent students he might chance to find in the Second Year Class And there the matter rested Until the other day It occurred to us, brooding over the problems of a troubled world, that possibly the emotion that most depressed the average human being was Fear

Wartime fear is universally understandable. The fears of so-called peacetime civilian life, which are even more comprehensible, are thought of less often

Fear of hunger, shabbiness, loss of reputation, loss of love Consider the emotional state of a surgeon emerging disabled from an automobile accident Of that of a physician who is being sent to a sanatorium with tuberculosis. He fears not only for himself, but for his wife and his dependents. Whether or not, in either case, his infirmities were incurred in line of duty, there is no "dulce et decorum est pro patria mori" for him. He is a failure, and he and his are going to be burdens on the community for the rest of his miserable life.

Up from the primeval slime of memory comes the impractical remark of that theoretic anatomist whose greatest interest was in comparative anatomy

The emotion, or whatever you want to call it, which caused the teleosts, from fear of the elasmobranchs, to leave the primordial mud, climb trees, and develop into a new winged species was not Sex, but Fear In case we have reversed the priority of the teleosts and the elasmobranchs we apologize to the comparative anatomist The Encyclopedia Britannica sheds no light upon the subject

In all sober consideration, is not Fear rather than Sex the primitive emotion?

Before the species can be propagated there must be survivors to propagate it "The man who fights and runs away will live to fight another day" He will see that he himself is secure before he lets lust overcome him and turns to the recreation of himself and his species

This is a hundred per cent revolutionary idea. We are knocking Freud and his disciples off their pedestals. But every book, every article that one reads today bears out the truth of the theory. Every trickle that leaks out from beneath the Iron Curtain says that while the Russians may not be very happy under Communism at least they know that they are all in the same boat

Misery is bearable provided that it is common misery. Certainly that is not a very clevating doctrine, nor does it seem a very worthy target at which nations should be content to aim their ambitions. But, to the old, tired, disillusioned, hungry nations of what remains of Western Europe, it is at least an idea. No one seems to take much account of the millions without the pale, even of Communism—of the sturving slaves, the displaced persons, the Jews. They seem to be simply written off the slate

To paraphrase Mr Franklin, Communism seems, except to those fortunate few who happen to find themselves in the drivers' seat, to offer to its followers the somewhat dubious satisfaction of "starving together rather than starving separately". And in order to obtain even that the individual must sacrifice everything he has of conscience, family affection, and individuality in general

Perhaps these elementary fears are well understood and taken into account by the medical profession in its daily contacts with those they fondly refer to as "ordinary people" We don't know, fortunately, how many snobs our profession has in it comparable to the political champion of the "common man," by whose wrongs his heart must be practically exsanguinated. We are sure that the doctor understands not the political but the ordinary troubles of the ordinary man, because he has them all hunself. We are not so sure about the Specialist.

If—or perhaps we should say more accurately—when, we are criticized for wandering afield from the narrow paths of medicine we aver that we are doing no such thing. If these primitive facts were more widely understood by physicians and by people we should not hear the universal frenzied appeals in the public prints of those who want psychiatrists to lean on, and who have none

#### Current Editorial Comment

Changing Customs in Medical Literature The New England Journal of Medical Courses the trend of the past seventy years toward more objective factual documentation in American medical literature. The editors of that excellent publication think this is a commendable step forward "producing clinical articles that are based on tabulation and the case protocols of specifically identified patients rather than on vague impressions". This change springs from more scientific and thorough training of medical investigators in fundamental research.

Some of the color, the vivid language of our ancestors in describing the clinical picture of disease has been lost, perhaps less by some of the English writers who "can report clinical material in a way that brings color, interest and humor to the cases"

Two abuses characterized by the New England journal as "becoming epidemic" are the 'sceretarial bibliography," aptly castigated as "a prostitution of the medical library", adding nothing to the medical literature, and the "puncheard article' This is a product of the machine age and one of which the editors of the New England journal think conservatively less than nothing as it applies to such human beings

When anthropometric data or the distribu tion of age, weight, and height among school children is being dealt with, the use of a puncheard system may yield material of much interest and information When, however, a puncheard statistical device is applied to clinical material that has an extremely variable background, the data that come from the machine may have little or no meaning. The old platitude that a chain is as strong as its weakest link might be paraphrased to state that statistical information on clinical patients is of as great value as the thought that has gone into its selection Merely to analyze a large series of tumors according to whether the patient had red hair or dark hair large ears or small ears and did or did not smoke cigarets adds little to knowledge, even though it yields numbers that have two significant decimal places and adapt themselves well to the drawing up of innumerable charts and graphs. As the anthropologist approaches a statistical problem, for example measurements of head size he puts in his punchcard system all the standard measurements of the skull that can be reproduced these are his varia-He then uses the machine as a device for singling out which of these variables are significant in relation to racial grouping sick human being however demonstrates so many thousands of variables that it is difficult

<sup>&</sup>lt;sup>9</sup> Sept. 4 1947 p 28.

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In Memoriam
Frederic E Sondern, M D
1867-1947

A past president of the Medical Society of the State of New York, well known as a clinical path ologat, Dr Sondern died on October 10, 1947, at the Post-Graduate Hospital, at the age of eighty, after an illness of several weeks. He was born in Stuttgart, Germany, came to this country at an early age, was educated in public and private schools in New York, and graduated from the College of Physicians and Surgeons with the class of 1889. He then served his internship at the old German now the Lenox Hill Hospital. For some years he was associated in practice with Dr Abram Jacobi and, subsequently, at the instigation of several of the outstanding physicians of that time, he founded and developed "The Clinical Laboratory" which achieved great prominence in being patronized by the leading medical men of the country

Dr Sondern became affiliated with the Post-Graduato Hospital, where he occupied the chair of clinical pathology from 1901 to 1923 He was also connected in this capacity with Roosevelt and Bellevue and served as Director of Laboratories at the New York Lyng In Hospital for many years

In 1935 he retired from active work.

During the greater part of his professional life Dr. Sondern interested himself in the work of organized medicine. He was President of his County Society in 1910, of the State Society in 1931, and a delegate to the American Medical Association for a long period. His membership in the Academy of Medicine was of long standing he was a Trustee for some years and very active in the Committee on Public Health. He was also Treasurer of the State Society and prominent in the establishment of the New York State Journal of Medicine.

Dr Sondern had a long and interesting career, both in his profession and in organized medicine. He was an earnest and indefatigable worker and his laboratory was a model establishment, known for its accurate and mediculous reports. His acquaintances and friends were many and varied both here and abroad. Almost every year he went to Europe to consult with foreign colleagues on advances in technical procedures, and his high achievements were recognized when the American Society of Clinical Pathologists made him its first president. Organized medicine found in him a capable and conscionatious worker. While in the ranks he wrote and spoke against all forms of socialized medicine, and year after year he developed and headed the antivivisection campaign in the Albany Legislature and did it most successfully.

The profession of this State owes Dr. Sondern a great debt for his labors. In behalf of the Society he was unstinting in the expenditure of time and effort. he was a wise counsellor a tried and trusted friend. Although mactive for a long time, he will be remembered among a large circle of friends and

associates for what he did.

## Scientific Articles

# PROBLEMS ENCOUNTERED IN THE TREATMENT OF CUTANEOUS CANCER

HERBERT L TRAENKLE, M D, Buffalo, New York

(From the Roswell Park Memorial Institute)

ANYONE who treats large numbers of cases of cutaneous cancer soon encounters many therapeutic problems which cannot be solved by the simple application of the particular therapeutic regimen that has been so successful in most of his cases. In such treatment problems, the approach must be individual. The probable result of every therapeutic modality available must be considered, evaluated, and compared

Throughout the literature on cancer therapy, so much attention has been paid to some particular routine treatment scheme that was successful in a large series of cases, so little attention to what has been done with the complicated and problem cases where the scheme could not be used, or where it had been used and had failed True, a large series of simple cases successfully treated with an easily applied treatment scheme is statistically impressive. But this is not very helpful when one is confronted with the problem of treating a case in which the routine cannot be used

To stimulate discussion of this type of case, we are making this brief preliminary report on a few examples from a large group of problem cases in which we are trying to evaluate and compare the efficacy of all available therapeutic modalities

The following cases, recently seen and observed, are discussed to illustrate our present attempts at the solution of therapeutic problems

### Lessons About the Nose

Cutaneous cancer occurring about the nose presented not only more frequent but also more difficult problems than any other category. The cartilaginous structure of the tip and ala of the nose does not tolerate irradiation or electrosurgery so well as the soft tissues. Also, scalpel resection is not so easily done in this area without considerable cosmetic distortion. Because of the position of the nose and its role in determining facial physiognomy, the cosmetic effect of treatment, while of secondary importance, unavoidably demands more consideration than cancer elsewhere

Case 1—J N, a 61-year-old white man, presented a diffuse lupus ery thematosus across the bridge of the nose and both cheeks with much atrophic scarring. On the left side of the bridge of the nose was a nodular ulceration which, upon curetting and biopsy, was found to be a squamous cell carcinoma, grade II Because of the atrophic scarring and the poor condition of the surrounding skin, it was felt that this was not particularly good tissue for irradiation. The lesion, therefore, was treated by very thorough electrocoagulation. When seen, six weeks later, the lesion had healed, and at the present time shows no sign of recurring tumor, but presents a firm, intact, healthy scar.

Case 2 -E D, a 62-year-old white woman, gave a history of having had a lesion on the nose for the past five years It was treated at various times with scalpel and electrosurgery On examination, the lesion consisted of a small ulcer just above the tip of the nose on the upper part of the cartilaginous por-This ulcer measured about 5 mm in diameter and was surrounded by a zone of telanguectases and atrophic scarring, involving a total area of about 1 cm in diameter The lesion appeared as though it might have been irradiated previously, but the patient denied this The curetted material from the soft center of the ulcer showed basal cell carcinoma As this woman was very well preserved, quite good-looking, and appeared much younger than she actually was, we were very anxious to get as good a cosmetic result as possible, in addition to removing her cancer All therapeutic modalities were considered, and the merits and demerits of each were carefully weighed It was felt that electrosurgery would cause too much destruction Because of the peculiar atrophic scarring already present, we decided against She, therefore, was referred to one of our plastic surgeons for excision and reconstructive re-

A V-shaped section of tissue, down to and including the cartilage, was removed, together with part of the nasal septum. The nasal tip was then brought upward and the margins sutured together thoroughly removed the cancer, but, because of the tip of the nose being drawn far upward, the immediate cosmetic result was not so good as might have been desired Therefore, two months later, the area was re-opened and an attempt made to bring the pasal disk down as nearly as possible to a normal position. The pedicle flap from the forehead was then rotated and sutured to the denuded area third operation is now being planned to smooth out the patch-like effect of the pedicle flap Although the patient is likely cancer-free, the immediate cos-

Presented at the 141st Annual Meeting of the Medical Society of the State of New York Buffalo Section on Dermatology and Syphilology, May 8 1947

metic result was rather disappointing to the patient, but was as good as could be expected after such an excision in that area

This case however illustrates that there is frequently a limit to the cosmetoe correction that can be expected with plastic surgery in the cancer patient. The large amount of tassue which must be removed often makes the mechanics of cosmetic correction extremely difficult. The greatest disadvantage of radical destructive surgery on the face is the long term disability the multiplicity of reconstructive operations and the great expense which may be encountered. In such cases, other methods may be more practical from the economic standpoint. This must be remembered in considering cases for reconstructive surgery.

Case 3 - J D C a 75-year-old white man, prosented a basal cell epithehoma on the right side of the nose just above the ala which had been treated twice with radiation during the past three years. Each of the previous treatments had been of rather This recurrence was in the form of small dosage multiple ulcerations in an area about 1 cm. in diameter presenting a rather patchy appearance. Electrocoagulation was considered as a possible thera peutle approach. However in view of the danger of penetrating into the nasal cavity it was decided to use soft radiation in the form of contact therapy with the Phillips tube Accordingly be was given 10 000 r at 50 ky over a period of five days So far the result has been excellent. It is difficult to see box a better result could have been obtained by any other means.

#### Lesions About the Ear

The car is secondary only to the nose as the site for the development of cancer that presents them peutic problems. These problems are due chiefly to the irregular contour of the inside of the concha making radiation mechanically difficult, and, also to the thin layer of the skin and subcutaneous tissue over the cartilage, which poorly tolerates radiation

Case 4.-- VI O a 75-year-old white man when first seen presented an exquisitely tender ulcerated area about 3 cm. long over the rim of the left car This lesion had received x ray therapy at various times during the preceding two years treatment was about six weeks before we saw him. On first inspection, it was difficult to determine whether the entire lesion was a radiation reaction due to previous therapy or whether there was still some epitheliomatous activity remaining. Biopsy was taken, which showed squamous cell carcinoma, Soft contact radiation was considered as a means of treating this lesion, but in view of the previous irradiation he had had, it was felt best to use some other modality Under local anesthesia the whole upper portion of the pinns was removed with the Bovie knife. When seen four weeks later the edges of the cut pinns were healing, and eight weeks following that the lesion was completely healed and has remained so ever since. The ear is cancer-free the cosmetic result surprisingly good.

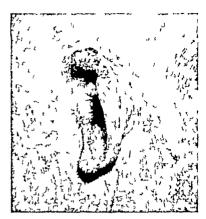


Fig 1 (Case 4) Squamous cell epithelioma of rim of ear

We have noted that removing part of the pinna in older people is not particularly disturbing from the cosmetic standpoint. The ear is not so conspicuous as the nose, and in a casual glance at an individual both ears are not seen at once. Thus, the asymmetry is not readily apparent. In women especially a few tufts of hair make it completely incon spicuous



Fig. 2. (Case 4) After excision of upper portion of pinna.

Case 5 — J C a 71 year-old white man, gave a history of having had a lesion of the left ear for the past eight years, for which he had received no treat ment of any kind On the lower portion of the inside of the conclus of the left ear there was a flat, nodular lesion about 1.2 cm. in length and about 0.5 cm. in width. Ulceration had not yet taken place. Biopsy revealed a grade III squamous cell carcinoma. The lesion was treated by curetting and thorough electrocoagulation. When seen four weeks after treatment, it was noted that the entire coagulated area had sloughed out, leaving a small penetration through the cartilage. However, when seen six weeks later, the entire area had healed, leaving a small perforation with clean edges. Furthermore, the entire area has remained intact ever since.

This lesion was treated with electrocoagulation partly because of the mechanical difficulty of irradiating the uneven contour of the concha, and because of the poor toleration of the cartilage for radiation. The patient is cancer-free and is cosmetically acceptable, because the small perforation is not conspicuous.

However, we have found that in the concha, electrocoagulation is applicable only to small epitheliomas. Larger lesions, especially squamous cell carcinomas of high-grade malignancy, are difficult to eradicate with this method. Such lesions should be excised widely with scalpel surgery.

## Lesions Involving the Scalp

Large epitheliomas of the scalp are usually difficult to treat either by radiation or by electrocoagulation, because of the poor tolerance of the cranial bones for both. We are more and more coming to the belief that surgical excision and plastic repair is the method of choice for scalp lesions of large size.

However, with the idea that soft radiation of feeble penetrability might be a simple way of treating these, in the following case we used socalled "contact" roentgen irradiation

Case 6—F R, a 74-year-old white woman, presented a fungating papillomatous squamous cell carcinoma about 4 cm. in diameter and about 1 cm thick in the midfrontal portion of the scalp. This had been present, untreated, for the past eleven years

Under local anesthesia, the top projecting portion of the mass was removed with the Bovie knife. The base of the lesion was then treated with so-called "contact" roentgen irradiation with the Phillips tube,

6,000 r were given at a single sitting

The treated area required several months to heal, but, eventually, a very fine result was obtained. The greatest disadvantage in this type of treatment was the mechanical difficulty of giving multiple exposures without overlapping in some places and missing small portions of the lesion in others. In some of our cases treated with this method, the results have not been satisfactory

## Lesions Involving Large Areas

Not infrequently, a lesion presents a therapeutic problem simply because of the large amount of surface area involved. Statistical studies correlating size of lesions with cure rate show a definite diminution of the latter when the lesions exceed 3 cm. in diameter. Large areas are sometimes difficult to irradiate uniformly, especially

if the surface is uneven, as, for instance, on the face. Also, large surface areas do not tolerate high dosages of radiation so well as small ones. In using electrocoagulation, much care has to be taken to cover completely the entire lesion with the coagulating tip. Frequently, small bits of the area are missed. We have used surgical excision and repair with split-thickness graft in many of these cases.

Case 7 -E M, a 51-year-old white woman, presented a large peripherally spreading epithelioma involving the left temporal area and forehead. The lesion had been treated repeatedly wih x-ray and electrocoagulation over a period of eleven years. In considering therapy, it was felt that further electrocoagulation, in order to be efficacious, would require extensive destruction with resultant scarring and deformity Further irradiation was, of course, out Therefore, surgical excision was of the question considered as affording the best chance of complete removal of the cancerous area and also the best cosmetic result Accordingly, under sodium-pentothal anesthesia, a large area of skin and scalp over the left forehead and temple region was excised down to and including the galea. Calibrated skin graft of 0 016 inch thick was cut from the left side of the chest with the dermatome This graft was laid over the denuded area and sutured in place

Although, in removing this lesion, a good margin of normal skin was included on all sides, six months after the excision a recurrence appeared along the inferior margin of the graft. This case illustrates the silent extension of the epitheliomatous process beneath normal appearing skin and the need for allowing very wide margins of safety.

## Deep and Penetrating Lesions

Deeply penetrating lesions present therapeutic problems because of the difficulty in determining the limits of the involved area, and in reaching the farther depth of the penetration with the therapeutic modality used The tendency of many basal cell epitheliomas to penetrate deeply and spread out under the normal skin, producing the so-called "silent extension," or "iceberg" type of epithelioma, is not sufficiently appreciated by many therapists We have used the curet in the exploration of many of these, and have been amazed at the extent of undermining produced by an epithelioma which appeared very small at the surface This is especially true of basal cell epitheliomas about the angle of the nose and in the inner canthi The work of Mohs has demonstrated histologically that there is frequently a great difference between the actual extent of the lesion and the visible ulceration, or even the induration felt 1 Therefore, regardless of the modality used in treating these lesions, a wide margin must be allowed. It is felt that such lesions, if not previously irradiated, can usually be handled quite nicely with x-ray, provided the

possible extensions of the lesion are taken into account when mapping out the field to be irradicted. If much depth is suspected or demonstrated, we believe filtered radiation is preferable

Case 8 -E. C., a 63-year-old wlute man gave a history of having had a lemon on his right cheek three years before This was treated by electrocongulation about one year ago but began to recur six months later. He presented a small scarred area about 1 cm in diameter on the right cheek. In the center of this was a nodular process which was just beginning to ulcerate. Upon curetting the soft area was found to extend to a considerable depth into the cheek and laterally in all directions under the normal skip The extension was most pronounced toward the inner canthus. Much epitheliomatous material was curetted out of the opening. The entire undermined area was estimated to be about 20 sq cm.



Fig. 3. (Case 8) Outline indicates limits of area irradiated in 'leeberg' type of basal collepithelioma.

A blopsy of this curetted material showed basal cell epithelioma. The area was mapped out and x ray therapy was administered at 140 kv using 0 25 mm. of copper and 1 mm. of aluminum. A total tissue doss of 4,000 r in a protracted scheme over a period of two weeks was given. The result so far has been excellent.

Occasionally an epithelioma arising in a sebaceous oyst presents a therapeutic problem The following case is illustrative.

Case 9—L. J., a 51 year-old white man when first seen presented a nodular lesion 1.5 cm in dlameter However below this was a freely movable cystic lesion at a considerable depth in the subcutaneous tissue. In deciding on therapy it was thought that both lesions could be removed at once with surgical excision. Accordingly an elliptical incision was made around the area and was carried down through the skin to the subcutaneous tissue. At this time it was noted that the overlying epithelioma extended into the eyst wall beneath. With the aid

of sharp and blunt dissection, the friable cyst wall and overlying skin was exceed

Upon histologic examination of the entire specimen, we were surprised to find that not only the over lying nodular lesion but the entire cyst wall was invaded by basal cell epithelioma, and that the two lesions were connected

One could not be sure that all of the friable tissue had been removed. Therefore, after the incision wound had healed, it was decided to irradiate the area which the cyst had occupied Although it is not ordinarily our policy to combine surgery and irradiation in the treatment of skin cancer, in this case because of the peculiar structure of the lesson and the question as to whether or not it was completely removed, we felt justified in so doing Furthermore the area of irradiation was mapped out by one who had seen the operation and who know exactly where the cyst had been. Irradiation given consisted of a total of 6,000 r with a tumor depth dose of 3 180 r given at 200 kv with 0 5 mm. of copper over a period of twenty-one days. The result so far has been good.

#### Problems Due Mainly to Previous Treatment

Not the least frequent among the problems en countered in the treatment of cutaneous cancer are those due to previous attempts at treatment. This is especially so in lesions which had been irradiated previously. The previous radiation therapy was usually that of insufficient and unfortunately frequently repeated dosage.

Case 10—R. L. a 69-year-old white woman, when first seen presented an atrophic searred area on the right check adjacent to the nose and pointing toward the inner canthus. There were some crusts under which soft tissue was found upon curetting. Biopsy of this material showed it to be a basesquamous epithelioms. The history here was one of repeated treatment for the past sixteen years. For the most part this had consisted of insufficient desage of radium and x ray with occasional electrocoagulation of a new recurrence. This palliative and patchwork type of therapy had through the



Fig 4. (Case 10) Basesquamous epithelioma in old scarred area pointing toward right inner canthus.

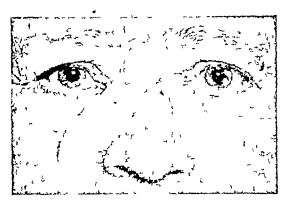


Fig 5 (Case 10) Five months after excision of the epithelioma and plastic repair with forehead flap

years, produced an ever-enlargening quilt of scar tissue and carenoma. If continued, this type of therapy would have ultimately caused the destruction of the right inner canthus and of the side of the nose

Ordinarily, an epithelioma in this location would not be much of a problem. But, in view of the previous ineffectual treatment over a long period of years with resultant scarring and destruction of the normal tissue in this whole area, further irradiation was thought inadvisable. Likewise, electrosurgery, to be complete, would have required complete destruction of a very wide area. This would have been slow to heal and possibly would have resulted in the formation of a chronic ulcer. Therefore, scalpel surgery with plastic repair was regarded as the modality of choice.

Under local anesthesia, the entire area was widely excised from the inner canthus up toward the side of the nose and down below the malar prominence, and in depth down to and including the periosteum A pedicle flap from the forehead was rotated and sutured to the denuded area. Five weeks later, the bulge formed by the rotation of the pedicle was excised

The lesson, so far, is cancer-free, and the cosmetic result is better than could have been obtained with any other method

Case 11—W D, a white man, 60 years old, gave a history of having had seven or more x-ray treatments over a period of about four months to a lesion on the left cheek. The exact amount of radiation which he had received was impossible to determine Examination of the lesion revealed a superficial ulcer about 2 cm in diameter with soft, undermined edges. There was no induration, nodules, or rolled borders

On the first visit, it was difficult to say whether this lesson was due to radiation necrosis, to cancer, or to both However, histologic study of curettings taken from the entire floor of the lesion showed basal cell epithelioma

In deciding on therapy for this lesion, it was felt that further irradiation would not be suitable in view of the indefinite amount he already had had. The other alternatives were scalpel surgery with excision and full thickness graft, or thorough electrocoagulation. Chiefly because of simplicity, the latter was

chosen So far, the patient is cancer-free and the result has been cosmetically good

## The Problem of the Hopeless Case

Although usually not discussed, we believe the problem of the hopeless case is worthy of mention. It must be admitted as a fact that we do see advanced cancer of the skin which we know cannot be cured. Once that is so decided in a given case, the further problem arises as to what should be done with the patient. Unfortunately, in many such cases, attempt at therapy frequently results in making the patient's plight much worse. The following is a case of point.

Case 12—N F, a 71-year-old white man, gave a history of having had ulceration which began on the right temple twenty-two years ago This lesion has slowly but continuously progressed ever since No therapy of any kind had been given

He presented an ulcerative destruction of almost the entire right side of the face, including the right eye and the frontal sinus. There appeared to be an extensive invasion of the bony structures almost to the meninges. The right orbit, for the most part, was destroyed. There was another lesion on the left cheek, cystic in character with very little ulceration Biopsy of both these lesions revealed basal cell epithelioma.

We believed that the lesion involved the bony structures to such a depth that radiation would produce extensive necrosis of the bone and probably a resultant meningitis Electrocoagulation was considered out of the question Likewise, we felt that the lesson could not be completely removed by scalpel excision without penetration into the meninges In other words, it was agreed that this lesion could not Further, it was felt that any attempt to do so would either kill the patient or convert most of his face into a large sloughing excavation tionably, he would be made more unsightly than he already was and be subjected to considerable physical suffering Strangely enough, he had very little discomfort at the time Briefly, anything that we would have done to this patient would have made him worse Therefore, the treatment of choice here was no treatment.

#### Summary

A conclusive evaluation and comparison of treatment methods as they apply to specific problems in cutaneous cancer cannot be made in this brief preliminary presentation. However, it is hoped that such observation on numerous cases over an extended period of time will permit more valid conclusions as to the preferable choice of therapeutic modality in a case that is more complicated than the average, and in which a simple routine type of treatment cannot be applied

### Discussion

Dr George C Andrews, New York City -- Many skin cancers can be cured by any one of several methods of treatment. There are others which specifically need treatment by one and no other method for instance, epitheliomas of the nose which usually call for x ray therapy and the epitheliomas of the rim of the ear which require surgical removal

There is another group the intricate cases, the difficult ones. In this each case presents an individ ual problem. That is the reason that discussion of

this group is not often undertaken

Whenever wide surgical excision is feasible that is Unfortunately, this is not always the best method Perhaps 50 per cent of the epitheliomas are favorable for excision The other 50 per cent are better treated by roentgen irraduation electrocoagulation, or some other form of therapy group includes most of the lesions on the nose and eyelids and those occurring in aged and infirm per sons. It also includes very extensive ulcerations which are too large for excision.

As stated by Dr Traenkle, contact x ray therapy has special advantages for epithelioma of the lids. Two most important considerations are the distribution of the radiation insuring adequate field coverage and adequate depth dose and second the

fractionation of the dose

Dr Traenkle mentioned the important work of Mohs. Everyone should see his models of the burrowings and "silent extensions" of the epitheliomas that he has studied. These illustrate that a small lump on the skin may silently and invisibly extend in various directions like an octopus or tinkertoy

Repeated recurrences after surgical excisions are undoubtedly often due to failure to recognize this clinical fact. Surgical success depends upon the removal of overy malignant cell The surgeon therefore must excise a wide margin of apparently normal tissue to be safe. "Success with radiotherapy depends upon the radiation effecting every cell in the tumor that is liable to divide it must either cause their death or render them incapable of further proliferation \* The results of radiotherapy in cutaneous cancers are often better than those of surgery

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\* Smithers D W The X ray Treatment of Accessible Cancer Baltimore Williams & Wilkins Co 1946

#### MANY MATERNAL DEATHS DUE TO HEMORRHAGE ARE PREVENTABLE

"Hemorrhage today outranks all other single causes of maternal death in the United States,' writes John Totterdale Cole M.D. in the September 20 issue of the Journal of the American Medical Association And yet he reports since the method of blood replacement now used at the Woman's Clinic of the New York Hospital has been adopted there has not been a single death from hemorrhage during 7 500 gynecologic operations. On the ob-stetric service only one death from this cause has

occurred during 14,000 deliveries.

In his article Dr Cole, who is a member of the Department of Obstetries and Gynecology at Cornell Department of Obstetries University Medical College and at the New York Hospital, points out the general need for procedures similar to those used by his hospital in combating that dreaded complication of pregnancy great loss of blood. The hasis of successful therapy he writes, ' is the rapid restoration of blood volume by the intravenous use of blood or plasma, preferably the former Dr Cole believes that fewer American women would die if the importance of the time factor were more generally appreciated. When blood transfusion is delayed abnormally low blood pressure can quickly progress to impending shock, impending shock to irreversible shock.

Among the practices of the Woman & Clinic of the New York Hospital which he emphasizes are Determination of the blood group and the Rh

type of all patients at their first "before delivery" Cross matching of the blood of all patients before delivery if it appears that a large loss of blood may One or more pints of blood will then be held on call for immediate use, at the central blood bankor, in case of occarean section in the operating room iteelf

Measuring the patient s loss of blood as it occurs so that it will not be underestimated.

When hemorrhage has occurred, shortening the duration of anesthesia by avoiding surgical procedures which can be postponed.

Keeping a small obstetric blood bank for emer gencies on the delivery floor itself in addition to the large, active general blood bank. The blood in the small bank should be of a type which may be used for any patient without preliminary typing or cross matching.

When an exceedingly large volume of blood has been lost rapid replacement by a simple pressure mechanism added to the ordinary transfusion appar atus. In such cases the drip method of transfusion is too slow

The administration of alkali agents to combat transfusion reactions and to delay the onset of irre-versible shock until enough blood and plasma are available.

Since the method was adopted, Dr Cole concludes ' there have been no deaths from hemorrhage during 3 600 major and 3,900 minor gynecologic operations. On the obstetric service one death due to hemorrhage has occurred during 14,000 deliveries. While the method has been in use there have been 250 postpartum hemorrhages.

# FIFTEEN YEARS OF ELECTROCARDIOGRAPHIC EXERCISE TEST IN CORONARY STENOSIS

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(From the Department of Medicine, New York Medical College)

OR many years spirited discussions were Theld concerning the mechanism responsible for anginal pain A great number of hypotheses were created and many phantastic ideas were defended Not rarely the abnormal condition leading to the pain was placed outside of the heart, in the autonomic nervous system, for ex-About fifteen years ago, the explanation that anginal pain is due to cardiac ischemia became generally accepted This conception is old and found support soon after the appearance of Heberden's classic report Voices were often raised against this explanation, but they were silenced when it was shown that during an attack of anginal pain, not caused by coronary occlusion, rather marked transient alterations appeared in the electrocardiogram 1 These alterations proved the existence of a temporary myocardial damage

The registration of the electrocardiogram during an attack of anginal pain, however, was restricted to patients with decubital angina was proposed, therefore, not to wait for that rare opportunity of obtaining an electrocardiogram during an attack of pain at rest, but to provoke an attack by physical exertion in order to diagnose coronary stenosis 2-6 In 1931 a report was published describing the electrocardiographic changes which appear during an attack of angina pectoris caused by exercise • The authors found marked changes in the electrocardiogram after exercise. but decided against the use of this method of examination for diagnostic purposes because, in their opinion, clinical findings are more significant than the electrocardiographic changes contradiction to this opinion the electrocardiographic exercise test was recommended for diagnostic purposes because the diagnosis of angina pectoris by clinical examination is for various reasons impossible 4,7 One must rely on the history which is often biased A method which enables the physician to diagnose the presence of coronary stenosis objectively should be welcome It is worthy of emphasis that the exercise test does not make it possible to confirm the presence of anginal pain, it merely enables us to diagnose the existence of a syphilitic or an arteriosclerotic coronary stenosis which forms the pathologic hasis for angina on effort in most cases

The test is based on the following simple principle Patients who have a coronary stenosis

have no pain and may show a normal electrocardiogram at rest because the blood supply to the myocardium is adequate. If greater demands are placed on the heart muscle by a faster rate, increased motility, higher blood pressure, and stenosis of a branch, or an orifice of a coronary artery prevents sufficient increase of blood supply to meet these augmented demands, relative ischemia of the heart muscle leads to electrocardiographic changes. Pain may or may not appear

The technic of the exercise test and its results were often discussed in articles and monographs. Therefore, only selected points and controversial questions will be discussed here.

1 The changes in the normal electrocardiogram following moderate exercise, like climbing stairs, were for the most part known to Einthoven They may be summarized as follows

The P waves become larger

The Ta wave becomes more pronounced and since it is negative with positive P waves and is of long duration, it may cause a depression of the RS-T segment below the zero line.

The QRS complex may show slight changes indicating a shift of the electric axis to the right. Thus, the R wave becomes smaller and the S wave sometimes deeper in lead I, these changes are due to the diaphragm which following physical effort assumes a

position similar to that in inspiration

The RS-T segment may become depressed below the zero line, at the same time the RS-T junction (J) is also depressed. This is partly due to the sinus tachycardia and a higher sympathetic tone. In view of the Ta wave the reference level for measuring the position of the RS-T segment is the level of the beginning of the QRS complex (the end of the P-Q segment). The downward displacement of the RS-T segment after exercise in the normal standardized electrocardiogram should not amount to more than 1.5 mm.

The T waves usually become higher and more peaked, but in some normal cases they become lower in leads I and II This fact is often overlooked and the unjustified diagnosis of an abnormal (positive) exercise test is based on it. This lowering of the T waves is particularly common in those healthy subjects who show the postexertional changes of the QRS complex in lead I which were discussed above.

The U waves are often more pronounced after

exertion.

Even after exhaustive exercise (marathon run) nothing more than the above changes are found. Unusually strenuous exercise may produce more

marked changes.\* On the basis of existing data it can be said that as yet there is no proof that pathogic changes characteristic for coronary stenosis, appear after exercise even in patients whose hearts are abnormal, provided the coronary blood supply is adequate.

2 The pathologic changes consist in a disappearance or inversion of the T waves in lead I and II and/or a depression of the RS-T segment which is more marked than that appearing normally A high take-off occasionally is observed for a few minutes after the exercise \*\*

Low take-off is much more common



Fig. 1 Positive exercise test in a patient with coronary sclerosis.

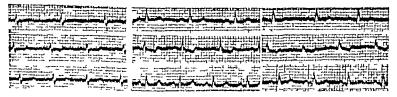
The upper row of tracings in Fig 1 shows the three standard leads of a 63-year-old man with an angina on effort caused by coronary sclerosis. There is a slight depression of the RS-T segments in leads I and II and the T wave in lead I is about mally low. After climbing two flights of stairs the electrocardiogram shows a sinus tachycardia (second row) with an abnormal depression of the RS-T segment, surpassing 1.5 mm. At the same time pain of the anginal type occurred. Five minutes later the electrocardiogram underwent even further changes (third row) and deep inverted T waves are visible in leads I and II. In the meantime the pain had subsided.

Another positive test in the standard leads is shown in Fig. 2. Here the electrocardiogram in the top row taken at rest shows only a low T wave in lead I and some slurring of the QRS complexes. Atter exercise, marked changes appear with inversion of the T waves in each lead Two minutes later (third row) the electrocardiogram shows nor mal positive T waves in all three leads.

Fig. 3 was obtained from a woman with syphilitic sortitis and angina on affort At rest, the electrocardibgram showed left axis deviation (first row) with a slight depression of the RS-T segment which is most marked in lead II it is within normal limits. After climbing one flight of stairs the tracings in the second row were taken An inversion of the T waves appeared in lead I and a greater depression of the RS-T segment occurred in leads II and III The T waves in the latter two leads are higher The patient felt a pain of moderate severity behind the sternum. Two minutes later when the electrocardiograms in the third row were registered, this pain was very severe. The electrocardiogram showed the same changes. Five minutes after the exercise the pain was still very severe but the electrocardiographic changes began to disappear (fourth They were still present fifteen minutes after the exercise when the pain had completely subsided at this time (fifth row) the T waves are inverted in lead II. The sixth series recorded twenty five minutes after exercise, showed not only the reappearance of positive T waves but the T waves were even more positive than prior to the exercise and during rest.

Occasionally electrocardiographic changes appear after an exercise test before the pain appears. Fig. 4 was obtained from a 45-year-old patient with cor onary schoosis. The electrocardiogram at rest (Fig. 4a) is normal. Immediately after running down one flight of stairs three times Fig 4b was taken. It shows a sinus tachycardia with a depression of the RS-T segment in lead I and in CR as well as CR. The patient was diszy but did not have any pain. Five minutes later when Fig. 4c was taken the patient felt some pain at this time the alterations in lead I and in CR, are more pronounced while they are already receding in CR1 utes after exercise, when Fig 4d was obtained, the changes persist in lead I there is an inverted T in CR, but CR, shows a normal RS-T and a positive T wave.

3 These tracings show a few facts which are often overlooked in performing the exercise test. In some patients the abnormal electrocardiographic changes appear early and disappear within two to three minutes therefore they are not present when the first electrocardiogram after the exercise is taken after the lapse of some time



F10 2. Positive exercise test in a patient with syphlitic sortitis.

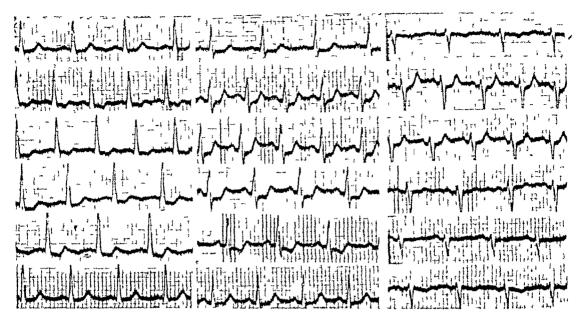


Fig. 3 Positive exercise test in a patient with aortitis

(Case 2) In other instances the changes appear late and in some of our cases they happened as late as ten minutes after the exercise <sup>10</sup> In the first few minutes after the exercise only higher, positive T waves may appear, that is, the same change as is seen in the healthy. Therefore, in order to be sure that one does not miss pathologic changes, the electrocardiogram should be taken before, immediately after the exercise, and two, five, and ten minutes after the exercise

The registration of the chest leads, particularly in position 5, is important because marked changes may appear in this lead and be absent in the standard leads

It is an important rule not to ask the patient to perform the exercise until pain is felt This procedure has been recommended recently but it is dangerous and unjustified In some cases even with the most marked pain electrocardiographic changes are slight or vice versa After exercise marked changes often appear at a time no pain appeared as yet, or when the pain had subsided spontaneously or with the aid of nitroglycerine Therefore the statement that electrocardiographic changes should not be expected if no pain appears is untrue It is equally inadvisable to standardize the electrocardiographic exercise test in such a way that patients evert themselves according to their sev, age, and The condition of the patient's heart alone determines the amount of exercise required A thin frail young woman with a syphilitic stenosis of both coronary orifices may develop alarming changes in the electrocardiogram after walking fast for only a few steps, an obese old man with hypertension may show pathologic and significant changes only when he climbs six flights of stairs after a heavy meal. Here, as elsewhere in cardiology, standardization often represents precisely the method of procedure which should be avoided. The degree of pain produced is not a measure of the electrocardiographic changes which may occur nor of the degree of my ocardial ischemia.

In order to avoid accidents which may be attributed to exertion by the patient, it is well to permit evercise only after a careful examination and electrocardiogram indicating that there is no

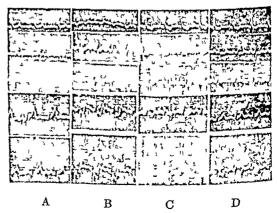


Fig 4 Positive evercise test in a patient with coronary sclerosis in this figure the five lends are beneath each other

contraindication against physical effort. Increased exertion should be undertaken by the patient only if the electrocardiogram after a less exercise does not show far advanced changes. If this precaution is taken the risks involved in the exercise test are negligible. The amount of exercise in the first test should not surpass the amount of exertion which every patient performs during his daily routine.

From the pattern of the electrocardiographic changes in a positive exercise test certain conclusions are possible as to the mechanism of their development. The usual changes are a depression of the junction J and of the RS-T seg ment with lowering or inversion of the T waves in leads I and II as well as in the apical chest leads over the left ventricle These changes are generally seen in patients with a damage of the subendocardial layers of the myocardium Simi lar changes appear during the administration of digitalis. The subendocardial layers of the myocardium are more sensitive than other parts of the myocardium to a diminished blood supply They are first severely damaged in chronic and acute anemia, in carbon monoxide intoxica tion and following the administration of large doses of digitalis. Due to this damage the du ration of the depolarization in these fibers becomes shortened it does not outlast the stage of depolarization of the subepicardial layers of the myocardium 11 This is known to lead to a depression of RS-T and T in leads I and H situation is reversed in the normal heart where the inner layers of the myocardium become depolarized early and are repolarized late

One of the more important arguments support ing this explanation is the after-effect in the electrocardiogram following a positive exercise test In cases in which marked changes (deep depression of the RS-T and T below the base line) are seen after the exercise very high positive T waves appear a few minutes after the depression of RS-T and T subsides In some cases these positive T waves are seen as early as ten minutes in others as late as fifty minutes after the exer-The T waves may become higher than they were before the exercise was done in patients who had inverted T waves before the exercise they may become temporarily positive after the pathologic changes subside (Figs. 2 and 3) There are reasons for assuming that damage of the inner layers of the myocardium causes depression of the RS-T segment and the T wave as an acute effect and high positive T waves as an after effect. In patients with damage of the subepi cardial (outer) layers of the myocardium, as in pencarditis an elevation of the RS-T segment and the T wave appears in the acute stage while an inversion of the T waves occurs later in the stage of repair. In rare cases of stenosis of a coronary vessel supplying blood to the subspicardial layer of the myocardium a temporary high take-off resembling that of acute myocardial infarction is seen after exercise 7.1 In one observation such a high take-off was observed regularly on exertion. The autopsy demonstrated normal coronary arteries but stenosis of the orifice of one artery.

Whether the changes are simply due to anovin or are the consequence of some damage caused by the ischemia is not certain but the latter is more probable. It has been shown by perfusion experiments that if the heart is per fused with solutions which are poor in oxygen or abnormally rich in carbon dioxide the described changes do not appear 12 Metabolic disturbances as the consequence of anoxia are most probably responsible This explanation is also favored by the experience that the pathologic changes in the electrocardiogram after the exercase test may persist for longer than forty min utes, when pain tachy cardin, and dyspnea have long disappeared 47

The lack of parallelism between pain and the alterations in the electrocardiogram is more readily comprehended if one considers that the pain is due to the accumulation of abnormal metabolites in the interstitual tissues while the electrocardiographic changes are due to an abnormal status of the myocardial fibers themselves

- The question whether the exercise test or the anoxemia test is preferable has often been discussed Both are of value The anoxemia test requires an additional apparatus and has some other disadvantages. While the exercise test has been found abnormal (positive) only in cases of coronary stenosis provided the exercise was not of unusual intensity the anovemia test has been found abnormal in patients with rheu matic fever in anemia and in endocrine disorders 12 The risks are greater since cerebral accidents and pulmonary edema do occur The border between the changes which occur in the normal and those which are found under pathologic conditions is less sharp doubtful cases of coronary diseases in which the diagnosis is difficult, the exercise test is more often positive than the anoxemia test 13
- 8 The effect of premedication on the exercise test has often been investigated <sup>4 in</sup> and it has been shown that papaverine aminophyllin and introgly cerine particularly the latter, when given shortly before the exercise test may convert an otherwise positive exercise test into a negative one. Changes are less conspicuous or even absent. In some cases the administration of

vasodilators will not change the outcome of the test and the conclusion will be justified in such an instance that compensatory dilatation of collateral vessels does not suffice to improve the myocardial blood supply

## Summary

The exertional changes in the electrocardiogram of the healthy and those which appear after exercise in patients with coronary stenosis are described

Typical electrocardiograms are demonstrated It is shown that marked changes may appear before the pain is felt or after it has subsided

Reasons which speak against standardization of the exercise test are given

The effect of medication on the result of the exercise test is described

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## MANY PATIENTS HAVE EMOTIONAL ILLNESS COMPLICATING PHYSICAL DISEASE

At least one half of all patients have their symptoms as a result of emotional difficulties in addition to and as a part of the physical disease, according to Raymond W Waggoner, M D, of Ann Arbor, Mich

"Every patient will respond more promptly to treatment of any disease if the physician understands and adequately handles the emotional as well as the physical aspect of the illness therefore it is essential that every physician, whether he is in general practice or in a specialty, obtain some understanding of psychiatric principles and utilize these principles in the treatment of all of his patients," states the author

Writing in the June 28 issue of the Journal of the American Medical Association, Dr Waggoner, professor of psychiatry at the University of Michigan, points out that only about two per cent of the registered physicians in this country are trained in psy-chiatric procedures, therefore the task of treating emotional illness falls upon the general practitioner

"Recognition of the importance of emotional factors in illness, a willingness to spend more time with such patients, an understanding of some of the motivating factors in such conditions, and the ability to help in the solution of such problems are essential characteristics of every good physician," states the author

The physician cautions that since patients tend to exaggerate symptoms of physical illness, great harm can be done by the prescription of unneeded rest

## MATERNITY IN NEW YORK CITY NOW SAFEST IN HISTORY

Never in history has maternity been safer than the present day, it was revealed recently by the Maternity Center Association. The Association emphasized that the United States, which once suffered a maternal death rate among the highest of any civilized country in the world, now is known to be the safest, with New York City in advance of all other sections of the nation

As recently as 1933, it was shown, the maternal death rate in New York City was 5 maternal deaths in every 1,000 live births, a figure that had been stable for more than a decade. It was then believed that the rate could be lowered to an "irreducible minimum" of 2 per 1,000. This figure was justified as "irreducible" in view of the fact that abnormalities and complications other than maternal causes must be considered

But so successfully has progress been made that in 1946 the maternal death rate in New York City had been reduced to 1 08 per every 1,000 births

Good hospital maternity service has contributed

much to the current maternity record During the past few years in a local hospital caring for more than 20,000 mothers, including many with abnormalities and complications, there was only one death from toxemia and 6 infection deaths In maternity services where only normal mothers are cared for, deaths from both toxemia and infection over a period of years have almost reached the vanishing point

The importance of hospital maternity care is further seen in the fact that today approximately 98 5 per cent of all babies born in New York City are delivered in the hospitals

The efforts of both professional and lay organiza-tions—such as the Maternity Center Association, the New York Academy of Medicine and other health and welfare agencies—in placing continued emphasis on health education and information, and in raising medical, hospital and nursing standards to higher levels, also have been a primary factor in reducing maternal mortality

#### CUTANEOUS ULCERATION IN ORGANIC CENTRAL NERVOUS DISEASE

Report of Trophic Ulcers in a Case of Postmeningitic Myelitis and in a Case of Dermoid Cyst of the Spinal Cord

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(From the New York Skin and Cancer Unit of the New York Post-Graduate Medical School and Hospital)

THE connection between cutaneous disturb-Lances and disease or injury of the nervous system forms too yast a subject to be dealt with This paper, therefore, is limited in one article to the discussion of cutaneous ulcerations observed in the course of ormnic disease of the central nervous system, in connection with the report of two cases The choice of this topic was stimulated by the thought that such lesions are rarely seen by the dermatologist, and better knowledge of them might help to diagnose earlier some cases of nervous system disease

Another thought was the desire to stimulate interest in the subject of the relation of the skin to the nervous system in general The close connection between these two systems, in utero and postpartum, and the not infrequent observation of skin changes in peripheral and central nervous disorders, justifies thorough study of this relation between the skin and nervous systems sults of such investigations might throw light on the etiology and pathogenesis of some skin diseases which, so far, are obscure in regard to causation, and in which nervous evatem disturbance might possibly be an underlying factor

#### Trophic Innervation

Cutaneous disturbances seen in association with disease of the nervous system are known under the term "trophic The problem of the existence of special trophic innervation has been discussed for many decades Although the existence of such nerves has not been proved, many clinicians use the term trophic nerves. scrutinizing the literature on this subject one finds that most of the authors are inclined to consider the trophic function of the nervous system as a combination of the function of sensory and vasomotor nerves leaving the fact uncertain whether there exist, in addition, truly trophic fibers and centers.

Trophic ulcers are accepted generally to be the result of degenerative changes in these nerves, leading to impairment or cessation of their function, in addition to trauma to the affected akin area, which is an important precipitating factor

It is logical to assume that analgesia plays an

important role in the development of these ulcers The inability to notice any injury deprives the skin of its most important protection which is given it by sensation of pain But this sensibility disturbance alone is not sufficient to explain the marked vulnerability of the affected skin areas and the readiness to form an ulcer even following a This fact and the poor tendency of mild insurv trophic ulcors to heal, has unavoidably led to assumption of special trophic impulses by specific trophic innervation 1

#### Trophic Ulcers

The different kinds of trophic ulcers seen in association with disease or miury of the central nervous system have essentially the same pathocenesis Their different clinical features are determined mainly by difference in location of the cutaneous lesion and somewhat, by the kind of underlying nervous system disease.

#### Malum Perforans

The oldest and best known trophic ulcer is the so-called malum perforans which is mostly seen in tabes domain-the prototype of disease of the posterior tract of the spinal cord

It is usually located on the sole of the foot under the first or fifth metatarsophalangeal joint, but may be seen on other pressure areas of the plantar surface, such as under the terminal phalanx of the big too or under the heel More rarely it is located on the tip of the toes and on the external aspect of the foot. It may be unilateral or bilat-Because of absence of the defense mechanism afforded by pain sensibility, a degree of friction and pressure is permitted which results in a callus, formation of a bursa, suppuration by infection, and destruction of the underlying tissues including bone. The ulcer is funnel shaped narrower on the surface than in depth, is surrounded by a hyperkeratotic border, and shows granulation at the base. The characteristic features of malum perforans are the hyper keratotic border, the noninflammatory appear ance, the insensibility to pain, and its persist-

Although this ulcer of the foot is most com monly seen in tabes dorsalis it has been observed also in other spinal cord lesions such as in lumbosacral syringomyella,2 in fracture of the verte-

Presented at the 141st Annual Meeting of the Medical Bociety of the State of New York, Buffalo Section on Dermatology and Syphilology Thursday May 8, 1947

brae causing hemorrhage into the cord<sup>3</sup> or compression of the cord,<sup>4</sup> and in vertebral tumor <sup>5</sup> In syringomyelia, in which the cei vical part of the cord is mostly involved, lesions are seen more often on the fingers, in contrast to tabes dorsalis in which the trophic ulcei commonly is seen on the foot. Among 91 collected cases of perforating ulcer of the foot, Gascuel found 61 which had central nerve lesions <sup>6</sup> Of these, 32 had tabes 17, general paresis, 4, traumatic disease of the cord, 8, various cord lesions, and 1 had Friedreich's ataxia

There is no doubt that in malum perforans of the foot the mechanical factor of pressure is of particular importance in determining the appearance and the course of the lesion

Although this trophic lesion in tabes is well known, the trophic ulcers of tabes located in other areas are less known, due to their relative infrequency, but also to their lack of particular characteristic features Their different clinical appearance is determined mainly by their differ-They may be located on the dorent location sum of the foot, the mesial aspect of the knee, and on the face This latter location has been reported in a number of cases, particularly by French authors, who term these lesions, buccal, nasal, and auricular mal perforant. Darier reported a case of such a trophic ulcer on the tongue and one on the nasal septum in cases of tabes 7 Others (Pierre Marie and Guillain,8 Giraudeau,9 and Jacques<sup>10</sup>) have reported such lesions on the nostrils and the ears Giraudeau described the buccal ulcer as round or irregular, sharply limited with no redness or infiltration in the borders The base is smooth and vivid red The area of the ulcer is analgesic but the tactile sense is pre-In buccal ulcers, the teeth loosen and fall out, the alveolar edge of the jaw is absorbed, and if the upper jaw is affected perforation into the antium takes place. Frey reported such a case of a trophic ulcer of the left nostril associated with painful falling out of teeth as a first symptom of tabes 11

The trophic ulcers on the nostrils in tabes do not seem to differ from those seen in encephalitis Such cases have been reported by Lammersmann, 12 Petzal, 13 and Schlittler 14 in Europe, and by Greenbaum and Alpers,15 and Rosenberg and Solovay,16 in the United States In these cases the history and course are surprisingly identical Several or many years after the appearance of Parkinson's syndrome, the patient develops pruritus on one of the wings of the nose, which he scratches continuously and produces a progressively enlarging ulcer, which leads to destruction of the nostril and adjacent parts of the cheek and lip Also in these lesions the teeth loosen and fall out Although trophic gangrenous ulcers in encephalitis lethargica have been described as located in other areas, such as on the hands (Büchler, 17 Adler, 18) and on the leg (Wielig and Biernig, 19) most reports deal with the loca tion on the nostril Why this particular location is favored for the trophic ulcer in Parkinson's disease is difficult to explain. According to Rosenberg and Solovay, 16 seborrhere dermatitis, which is so frequent in encephalitis lethargica, may have some influence on the development of these ulcers The statement made by Purves-Stewart<sup>20</sup> that complete section of a cutaneous nerve may lead to cutaneous pruntus in the skin surrounding the anesthetic area, leading to chronic scratching and ulceration, may be of interest in this connection, for in most of these reports the identical history of pruritus and continuous scratching is obtained

The importance of trauma as an exciting factor in the production of these ulcers is obvious. Primarily, however, these ulcers are to be considered as a late complication of encephalitis lethargica, although on an objective sensory examination only some decreased pain sensation or diminished tactile sensation is detected in the area of the ulceration. A case of a similar trophic ulcer on the left ala nasi, following a head injury, was presented by Costello at the Atlantic Dermatological Conference in 1940.

#### Decubitus

Decubitus is another clinical form of troplic ulcer which is distinguished by particular location and by the fact that it is found mostly in patients laid up in bed for a long time with a serious disease, most often of the central nervous system This type of ulceration has been known also for many decades, Samuel being the first author to describe it in 1860 22 The acute type is seen most frequently and typically in cases of hemiplegia due to cerebral hemorrhage, in which it is located in the gluteal region, on the side opposite to that of the cerebral lesion In spinal cord lesions it is situated in the middle, over the sacrum, and in myelitis with the Brown-Sequard syndrome, on the great trochanter, on the anesthetic side Less characteristic locations are the heel, the ankle, the scapula, and the knee The lesson starts with an erythematous spot which forms into a bulla, then into a black crust, and finally into an ulcer which rarely heals, but more often leads to general infection or pulmonary septic embolus and death It may reach by deep extension the sacrococcygeal canal and infect the meninges by extension upwards Because of the serious prognosis of cases afflicted with acute decubitus, Charcot termed it "ominosus" cubitus rarely is seen in poliomyelitis observed it over the sacrum or the heel in cases of lateral cordotomic for pain due to vertebral cancer <sup>23</sup> Charcot and Kaposi have seen acute decubitus mostly following brain abscess <sup>24</sup>

Although the mechanical factor of pressure and contamination of the skin with urine and feeal matter plays an important role in the production and peristence of the decubital ulcer in the chronic form the trophic disturbance of the skin is, particularly in the neute decubitus, of primary importance. This explains the rapid development of decubitus in scrious diseases of the central nervous system within a few hours or days, in contrast to the cuses of cardiac disease, nephritis and cancer in which eschardue to infection develops after weeks or mouths of confinement to bed

The precipitating external factor of pressure in decubitus does not differ essentially from that in malum performs. The explanation for the climical difference in these two forms of trophic ulcers may lie in the fact that the underlying nervous system disease in decubitus usually is more severo than in malum performs. Decubitus is most typically seen in hemiplegia hemorrhage into the spinal cord, abscesses or acute softening, spinal

cord mjury, etc 35

While malum perforans nasal lesions in tabes and particularly in encephalitis lethargica and decubitus form special types of trophic ulcers with characteristic clinical features, other trophic ulcers have no special peculiarities in regard to location or appearance. Here belong ulcers observed in spinal cord tumors, mychitis, syringomyella, and Friedreich's disease. According to Elsberg trophic ulcers are rare in cervical and thoracic cord tumors, but not infrequent in lumbosaeral and cauda equina growths.

My report of 2 cases, observed at the Skin and Cancer Unit on the service of Dr I Rosen deals with trophic ulcers of the latter type One deals with a gangrenous ulcer in a tumor of the lower spinal cord and the other case with trophic ulcers in myelitis following meningitis

### Report of Cases

Case 1—J S a man aged 48 born in Germany a milk platform man by occupation, had registered at the Skin and Cancer Unit on December 20 1040 He complained of an ulceration of the left heel of one week duration and of a similar lesion on the left but took which had been present for eight months.

On examination the posterior aspect of the left heel presented a gangrenous ulcer measuring about 2 by 4 inches in diameter and involving mostly the external and inferior aspect of the back of the heel (Fig. 1). The borders were well marked and surrounded by a zone of crythema. The peripheral area of the ulcer was covered with granulation tissue which contained small black necrotic spots. The middle and lower portion of the ulcer which was considerably depressed formed a mass of black

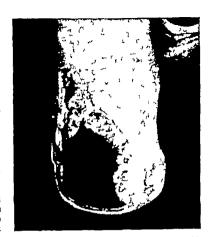


Fig 1 (Case 1) Gangronous ulcer of one week's duration on left heel.

necrotic tissue The patient stated that for the past several years previous to the development of the ulcer this area of the heel was fasured and hyper keratotic The ulcer which had started a week previously to the visit at the clinic had been enlarg ing gradually

On the lower part of the left buttock there was a superficial ulceration oval in shape of 11/2 by 1 inch in dameter well-defined, and surrounded by an crythematous zone (Fig. 2) The ulcer started in April 1940 and became worse in May 1940 but had shown a tendency to heal since then

The patient complained of pain at night in the area of ulcoration. His past history was irrelevant except for constipation which at times was so severe that he did not move the bowels for a period of three days.

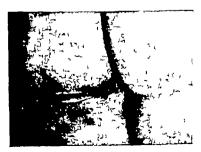


Fig. 2. (Case 1) Trophic ulcer of eight months duration.

Because of negative laboratory findings, including urine, Wassermann and Kahn reaction of the blood, blood chemistry and count, and because of exclusion of arteriosclerosis in the patient, a possible neurologic condition was assumed and the patient was referred to the Neurological Department of the Post-Graduate Hospital He was admitted to the service of Dr George Blakeslee, on December 31, 1940

The following neurologic status was noted. The cranial nerves were essentially normal. The deep reflexes of the upper extremities were active and equal. The left patellar reflex was more active than the right, and the Achilles reflex on the right was absent while on the left it could not be tested. The abdominal reflexes were active and equal. There were some myocolonic movements in the left gluteal muscles. The plantar reflexes were mildly active. No Babinsky reactionnor confirmatories, no Hoffman reaction now clonus could be obtained.

Coordination examined by the finger to nose and heel to knee tests were normal. Sensory examination revealed, anteriorly on the left, an area of hyperesthesia extending from the level of the umbilicus down to the middle of the left thigh, and, posteriorly, a saddle area of anesthesia and analgesia extending to the middle level of the thighs.

In questioning the patient it was revealed that he had some urinary disturbance, as he did not seem to feel the urine passing and was not aware when the bladder was full.

The spinal fluid examination showed slight vanthochromia as the only abnormal finding

Roentgenogram of the lumbar spine, after injection of the cisterna, showed evidence of obstruction in the spinal canal, at the level of the inferior margin of the second lumbar vertebra. In spite of the obstruction some contrast fluid found its way slowly along the periphery, latero-anteriorly

The diagnosis of neoplasm of the cauda equina was

The patient was transferred to the Neurosurgical Service of Dr Arthur MacLean The operation was performed on January 16, 1941, under intratracheal anesthesia. An incision was made over the spinous processes of the second to fifth lumbar Following incision of the dura, a smooth. soft, doughy-like mass was exposed, around which the cauda equina roots were compressed to fine The mass was excised in the ribbon-like structures midline, and two test tubes full of soft matter of putty-like consistency were removed, in which many short hairs imbedded in sebaceous material were A soft cartilaginous-like substance was also removed At the completion of the curettage, the superior pole of the sebaceous sack was dissected free, where it apparently arose in the filum terminale

Dissection was carried down into the upper sacral portion of the spinal canal, and additional sebaceous matter was found in this junction which was curetted. The dura was closed after aspiration of about 3 cc of lipiodol, which appeared in the exposed area on removal of the sebaceous sack.

The final diagnosis was dermoid cyst of the cauda equina and the spinal cord

The patient left the operating room in good con-

dition, but on January 18, 1941, while he was being turned on the side, he died suddenly of an embolus'

Case 2 — PB, a negro girl, aged 3, was referred on June 8, 1945, from the Pediatric Department of the New York Post-Graduate Hospital to the Skin and Cancer Unit, because of an ulceration of the vulva, which had been present for the past two years

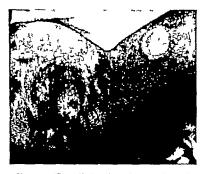
On the lower part of the left labuum majus there was a well-marginated, clean, smooth reddish ulcer of about 1½ by 1 inch in diameter, with indurated borders (Fig 3) The ulcer was painless and not tender. In the left groin there were a few enlarged, hard glands which rolled easily under the finger and were not adherent to the skin.

The child had paralysis of both lower extremities. The following history was obtained when the child was admitted on July 4, 1945, to the Pediatric Department, service of Dr. A. Ashton. At the age of six months the child underwent an operation for an acute left mastoiditis. Two weeks after she had apparently recovered from the mastoidectomy, she developed pneumococcus meningitis which confined her to the hospital for about three and a half months. Since that time she had paralysis of the legs and urinary and fecal incontinence. Six months later, she developed the ulceration on the left labium majus, which in spite of any treatment did not heal

On examination by Dr George A. Blakeslee the following findings were noted. The right pupil was 4 mm in diameter, and the left, 3 mm. The left pupil reacted more promptly to light and accommodation than the right. The right palpebral fissure was wider than the left. The deep reflexes were lost, except that of the triceps, which was diminished.



Fig 3 (Case 2) Trophic ulcer of two years' duration



Fro 4. (Case 2) Trophic ulcer of the vulva almost healed and a now ulcer at the inner aspect of the left thigh

The abdominal refleves could not be clicated. There were no plantar and no Babinsky reflexes. There was a loss of psin sensibility from the plantar surface of the feet up to the thoracic eighth at the left and at the right. The diagnosis of meningo-encephalomyelitis was made.

A biopsy from the edge of the ulcor of the vulvn showed chronic inflammatory reaction. On ac-



Fig 5 (Case 2) Low-power microphotograph of the edge of the trophic ulcer showing organizing granulation tissue with overlying acanthogia.

count of this report, together with the negative bacteriologic and serologic findings particularly regarding syphilis and because of the association with central nervous disease the diagnosis of trophic placer was made

Since then the patient was observed by us from time to time and the ulcer treated by attention to cleanliness and mild ointments On November 25 1946, the lesion on the left vulva was almost healed but another ulcer was observed on the inner aspect of the right thigh near the groin It was a half dollar sized clean, red smooth, well-defined ulcer ation with raised borders. Acording to information obtained from the mother, this ulcer had been present for two months and she attributed it to the pressure of the brace which the patient had to wear (Fig. When seen in December, 1946 the ulcer on the vulva had healed ontirely with scarring and depic mentation but the ulcer on the thigh did not show any tendency to healing On January 6 1947, a biopsy was taken from the edge of the new ulcer and the following report was made by Dr W Sachs. "The epidermis is tremendously acanthotic and is covered by a pronounced densely laminated horny layer beneath which is an increased granular layer There is no edema of the epidermis and the palisade layer is intact. In one edge of the section there is some necrosis of the surface. In the lower portion of the epidermis there is considerable pigmentation.

"Throughout the entire cutis there are numerous blood vessels of all sizes and shapes. Around the vessels there is a focal cellular infiltration composed of small, round cells, wandering connective tissue cells, and plasma cells. Between the vessels there is considerable increase in fibrous tissue (fibrosis) within which there is a moderate diffuse fibroblast cell infiltration."

Diagnosis Organizing granulation tissue with overlying acanthosis (Fig. 5)

In February 1947 this new ulcer had also healed but soon after it reappeared again. On April 4 1947 the ulceration of the left lablum majus had again recurred and there were in the permeal region numerous pear-sized ulcers surrounded by whittle, raised borders. The mother informed us that because of illness she had to neglect the care of the child who required strenuous attention because of incontinence When seen on April 25 1947 all the ulcers had healed and were covered with depigmented skin.

#### Comment

Case 1 has several points of interest worthy of consideration. It is of course, clear that the location of the growing dermoid cyst compressing the spinal cord and the cauda equina has determined the location of the ulcers with friction and pressure being a secondary though important factor. The fact that no marked sensory disturbance has been found in the area of the gangrenous ulceration on the heel leads the clinical observer to the thought that probably trophic innervation has been disturbed on which the normal metabolism and life of tissues depend—whatever

one may understand under the term "trophic" One may assume specific trophic nerves or one may conceive trophism to be a result of a harmonious combination of different nerve systems, particularly of the sensory and vasomotor apparatus

Of importance seems to be the fact that the gangrenous ulcer was preceded by hyperkeratosis and fissuring of the skin for a period of several years, and that the superficial ulcer on the left gluteal region had been present for about eight months before the spinal tumor was detected Hyperkeratosis as a manifestation of trophic disturbance of the nervous system frequently is mentioned in the literature, among others, by Pusey. The Campbell, 28 and Foerster 29

It is pertinent to conclude from the above facts that any ulceration and hyperkeratosis of the skin not otherwise explained should make one think of the possibility of an underlying nervous system disease A part of every thorough general examination should be attention even to minor lesions of the skin and consideration of troplic nervous disturbance in the differential diagnosis Had this rule been followed in this patient the diagnosis of a spinal cord tumor might have been made much earlier Any additional means of detecting a tumor of the cauda equina must be welcome to the neurologist In some cases of these tumors neither objective nor subjective motor involvement is found, and sensory disturbances may be so slight that only a suspicion of hyperesthesia over a root area can be discovered 26

In Case 2, it is of interest that the first trophic ulcer appeared on the vulva, six months after development of the paraplegia This fact is in agreement with observations made on the nasal trophic ulcers in encephalitic lethargica and in cases of nerve injury Mucha states that disturbed trophic functions of the skin may persist as a latent condition for a long time and eventually become manifest 25 Head, in experimenting on himself, observed the development of an ulcer three months following section of a nerve 30 The observation in Case 2 of comparatively rapid healing of the ulcer by paying attention to cleanliness, and thus avoiding maceration and infection, and, on the other hand, the reappearance of the ulcer when the care of the child was neglected, emphasizes again the importance of external factors in the formation of trophic ulcers. This observation seems to be in agreement with the statement of Bechterew, 21 who maintains that cellular tissue and skin can nourish themselves after having been deprived of any nerve connection, and with the observation of Mitchell32 that loss of innervation does not prevent cicatrization, which is proved by quick healing of gangrenous lesions produced by pressure in paralyzed patients

## Summary

- 1 Two cases of trophic ulcers were reported, one in association with dermoid cyst of the cauda equina and the spinal cord, and the other in acase of postmeningitic myelitis
- 2 The problem of specific trophic innervation was discussed
- 3 Trophic ulcers were divided into those with special characteristics malum perforans, decubitus, and nasal ulcers seen in tabes and in encephalitis lethargica, and into uncharacteristic ulcers seen in other different central nervous diseases
- 4 A plea for greater consideration of nervous system disease as an underlying factor in skin diseases is made

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#### Discussion

Maurice J Costello, M D , New York City — Dr Bloom has brought to the attention of the derma tologists the importance of the recognition of trophoneurotic ulcerations in the diagnosis of lesions of the central nervous system I believe he proved the causal relationship in these cases

I prefer the name trophoneurotic ulcer rather than trophic ulcer because the former appellation means an ulcer due to nervous disease of central origin whereas a trophic ulcer might be interpreted as one due to imperfect nutrition of the part

The absence of sensibility to pain, caused by degenerative changes in the nerves and trauma, is the factor which enhances the occurrence and perpetuation of these trophoneurotic ulcers, the most common example of which is the malum perforans occurring on the plantar surface of the feet

I have seen several examples of trophoneurotic I should like to describe briefly two which illustrate further the condition The first, presented before the Atlantic Dermatological Society in New York (Arch Dermat & Syph 42 685 ((Oct ) 1940), was a trophic ulcer of the nose The patient, H A., a man aged 47, a watchman, was first seen in Novem ber, 1938 He gave a history of sudden loss of speech and of a tingling sensation in the left ade of his body several days before a diagnostic spinal puncture was performed He stated that a sore appeared on the left ala nası on the following day While in the hospital he complained of excessive sweating limited to the left side of his body had an injury to the left side of his head twelve years before, accompanied by transitory hemiplegia. Examination revealed an ulcerating lesion of the left nostril with some destruction of the left ala nasi He also had a proliferative ulcerating lesion on the septum resulting in occlusion of the left nostril There was beginning atrophy of the septal cartilage In an area extending about one inch (25 cm) around the left nasal aperture there was a zone of reduess and scaling

Neurologic evamination showed generalized hyperreflexia, with bilateral Hoffman signs, and equivocal Babinski signs There was a transitory ankle clonus

No tubercle or lepra bacilli were found on the right on scraping the affected areas. Culture of the material showed Staphylococcus aurous, a few hemolytic streptococci and Micrococcus catarrhalis The Wassermann and Kahn reactions of the blood were negative on five occasions Blood counts were normal except for mild leukocytoms The urine was normal. Histologic examination showed papillary hyperplasia of the stratified squamous epithelium. hyperkeratosis, a small area of ulceration, and an acute inflammatory reaction. In the submucosa there was dense connective tissue with considerable inflammatory reaction. Histologic diagnosis was hyperkeratotic papilloma. The patient received several doses of neoarsphenamine and saturated solution of potassium iodide without favorable effect on the lesion, which healed eventually with great care provention of mechanical irritation and pick ing and with cleanliness and hygiene

A second example observed in the dermatologic wards of Bellevue Hospital, was that of a Sootchman aged 50 who had almost complete destruction of the left ala nasi following a severe attack of influenza associated with symptoms of encephalitis other possible causes of this lesion, such as syphilis, tuberculosis leprosy and trauma were ruled out

These two cases resemble those reported by Rosenberg and Solovay under the title, 'Trophic Ulcer Following Encephalitis Lothargica ' (Arch Dermat. & Syph. 39 825 (May) 1939)

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#### THE DANGER OF METALS IN THE DIATHERMY FIELD

The spectacular advent of short-wave diathermy some fifteen years ago raised a number of problems as to its physical and physiologic effects and their bearing on practical uses. Extensive clinical and experimental work solved most of these problems and established the scope of employment and the safeguards of the technic of diathermy as a deep tissue heating agent. Among the earlier assertions disproved was the claim that certain wavelengths exert selective heating in the living tissues it was shown that the blood flow and the rapid interchange of heat in the living body will equalise any differ ence in heating of heterogeneous tissues in the depth. It was also shown that wavelength in itself plays a less important role in heating than the power output of the apparatus, the energy delivered to the petient, and the technic employed. In recent years with the increase of implanting metals in the tissues of the body by surgery a newer problem came to the fore, that of the potential danger of postoperative use of diathermy in these cases. Two comprehensive studies presented in the Archives of Physical Medicine should clarify this bothersome question. The observations of Etter et al. started as a watume research, disclose that histologic examination of tissues contiguous to metals showed no evidence of destructive effects from disthermy under ordinary treatment conditions. To a certain extent this appears to be in accord with the earlier cited observations about equalization of heat in the deeper

Lion's experimental setup corroborates the fact that with metals embedded deep in the tissues, the field concentration is of little practical signifi cance however overheating of tissues may still occur around metallic parts located on or near the surface. Hence, it may be safely stated that with surgical metals situated in the deep tissues and with no evi dence of impaired circulation, there is no danger of overheating with disthermy when standard clinical intensities are applied with the usual careful technic. -Archives of Physical Medicine June, 1947

# THE PREPARATION OF ELDERLY PATIENTS FOR LARGE-SCALE OPERATIONS

ABRAHAM O WILENSKY, M D, New York City

DISEASE of the caliber necessitating largescale operations has always existed for
such a long time that the patient generally shows
the effects of the illness in a depreciated state
marked by loss of stamina or "pep," loss of weight
and strength, various degrees of fatigue, the absence of the normal sense of well-being, and a
much lessened resistance to disease and to bacterial and other trauma of all kinds. This spells
lessened resistance to operative procedures. In
nearly all cases this state of affairs is tied up intimately with protein deficiency states, with
anemia, and in many cases with latent liver
changes both in function and later in structure

## Protein Deficiency and Hypoproteinemia

A general deterioration caused by protein deficiency and hypoproteinemia has been shown to be tied up with the albumin and globulin fractions of the protein metabolism 'The relative importance of the various protein fractions is In operative cases the now being understood assurance of an adequate supply of protein is most important for the following reasons The proteins protect the liver from the possible touc effects of anesthesia (2) They guard the body's ability to replace its losses through ordinary wear and tear as well as through extraordinary periods of disease and as a result of operative (3) They increase the ability and procedures readmess of wounds to heal by preventing tissue edema, and by supplying the essential nutrients required for tissue repair and regeneration proteins protect one against infection by increasing the antibody protection of the body furnish the factors which regulate blood clotting and control hemorrhage And an abundant. rich protein supply does away with fatigue, gives a sense of well-being and vigor, and helps in maintaining a proper cheerful frame of mind in the vicissitudes of large scale operations

The emphasis which has been placed on correcting dehydration and electrolyte losses before and after operation has often been accompanied by failure to consider the mechanism involved in keeping fluids in the blood vessels (Starling hypothesis) Proper control of the fluid and electrolyte balance in surgical patients receiving parenteral fluids is not possible unless the serum-protein concentration is maintained within normal limits

Minerals are also important in the body They add to the general effect of a sufficient protem supply, and they provide the necessary bases

The measure of any protein deficiency can be approximated by repeated estimation of the blood plasma level of protein Whereas the normal level varies from 5 6 to 6 5 mg per cent, many of the patients, even though superficially they may look well nourished, have levels below this When, in the presence of low levels, the patient looks in good condition, it is well to assume that the protein reserves are not so abundant as they should be When the patient obviously looks undernourished, or even cachectic, it must be assumed that the protein reserves are depleted to an extent which would increase the risk of operation, handicap the recovery therefrom, and interfere with the subsequent healing

## Anemia

Varying degrees of secondary anemia are constantly present and are related to any coexisting hypoproteinemia. The anemia, of course, depends upon any hemoglobinolytic effect of any malignancy and upon the amount of bleeding which has preceded In general, when faced with these extensive operations, transfusions of whole blood are most advantageous When the hemoglobin level and red blood count is below 60 per cent, I consider preoperative transfusions mandatory When the figures are somewhat higher, one may sometimes omit the transfusions before operation and use other methods of supportive build-up, but, in many of these cases, the transfusion should be given directly after operation in order to help counteract the trauma of the operative procedure Many times it is advantageous to transfuse the patient both before and after operation When repeated transfusions are necessary, the Rh factor must be investigated

An important point, usually not appreciated, is that the protein deficiency and anemic states exist for a long time, their restitution to the normal by pure replacement therapy cannot be done quickly. The important item to replace is the normal reserve supply of protein, and this can be built up gradually only by repeated and persistent effort.

In the preoperative preparation of patients with malnutrition, protein deficiency, hypoproteinemia, and anemia, one must consider the double nutritional disturbance resulting from first, the primary illness (gastrointestinal disease with either vomiting and/or diarrhea, carcinoma,

dysentenes, hyperthyroidism, hepatic disease, and so on), and second, the operation itself

In calculating the daily necessary amount of protein, the following factors must be considered (1) the patient's nitrogen balanca, (2) the estimated degree of deficiency in the tissue and reserve protein, and (3) the possible con tinuance of the original disability which caused the deficiency if one exists, finally, an additional amount of protein should be given to allow for any unayordable error in the computation

One can calculate the daily requirement as follows

(MED+DL+NUP) × 2

MED = minimum endogenous daily protein need usually 25 Gm,

DL - daily loss of protein determined from

NUP = part of diet which is not utilized (estimated)

The factor 2 is chosen arbitrarily to make good any error and to furnish the additional protein from which the contemplated gain is to be made in the correction of the protein deficiency. This calculation can be made quite easily, and such amounts permit the subject to regain the normal protein content with a speed that the body can tolerate. In good subjects, the arbitrary factor 2 can be ruised to 3, and even 4. The presence of any hepatic parenchymal disease of any grade makes for difficulty because of the inherent inability of the diseased liver to metabolize the administered protein.

If no success follows in the mild cases or it follows in manificient degree, if the grade of the protein deficiency is severe or extreme, or if there is any necessity for urgency in the correction of the hypoproteinemic state, more active measures are necessary, including the parenteral replacement of protein. Parenteral replacement of protein. Parenteral replacement of protein can be accomplished by (1) the transfusion of fresh whole blood, (2) the transfusion of wet or dried human plasma, (3) the reinfusion of human transudate fluid (ascitic and/or pleural), and (4) the use of amino acids

#### Cardiovascular and Renal Disease

When cardiovascular disease is present, it necessarily becomes a major item in the preparation for operation. The patient either has hypertension or cardiac disease proper and/or coronary artery disease as the major factor

Most patients in the later periods of life have more or less hypertension. Usually this does not influence either the choice of the method and/ or the drug used for the anesthean nor the conduct of, and/or the reaction to the operature procedure In bad hypertensive cases, especially with renal manifestations and persistent grades of asotemia, the risk of operation is considerable. It is regrettable, however, that the usual methods aimed at reducing hypertension are not so effective as one would like. Nor is there any available method of estimating the operative risk under such conditions.

The problem with cardiac disease proper is different. The main items include the amount of myocardius present, the degree of cardiac compensation, and the effective amount of cardiac reserve which are present. In any case the condition of the lungs and the likelihood of any bronchopulmonary edema must also be considered.

The preparation of patients with selectic valvular disease is not too difficult. Unless a myocarditis of an extensive grade is also present, the cardiac mechanism can be brought up quickly to a satisfactory state, and then there is little or no difficulty either immediately or in the subsequent postoperative period. The main reliance should be put on rest in bed and the use of digitalis and/ or of quinidine where indicated

The preparation of patients with coronary disease is an entirely different and a more difficult matter. The patient should never be without the attention, and the surgeon should never be without the help and advice, of a competent cardiologist. The following are important items in considering the risk of operation.

- 1 An important factor is the length of time between the onset of the coronary disease, especially of any initial acute closure, and the performance of the operation The longer this period is, without any further or repeated coronary epi sodes of coronary closures, the less risk there is. The condition is somewhat different when the closure is a long, slowly occurring affair
- 2 The degree of muscular involvement in the infarcted cardiac area determines the degree of cardiac compensation and the extent of cardiac reserve. At the present writing, there is no method whereby one can measure the reserve capacity of a diseased heart with any degree of acouracy especially for the judgment of a surgical risk. This is one of the most difficult items for consideration in the preparation of these patients for surgery.
- 3 Embolic phenomena are common in cardiac disease, especially in acute coronary closures. The important ones occur in the brain the lung and the kidney. When the disturbance created by one, or more than one of these embolic lesions in sufficiently great, operation should be refused as the risk is almost absolute. This is one of the times when experience and judgment are the best guides.

Cerebral Episodes.—The occasion arises when one must operate upon an individual who with or without preceding cardiac disease, has gone through a cerebral accident, either embolism or hemorrhage The important items upon which judgment is based include (a) the length of the interval since the occurrence and the recovery from the cerebral episode, (b) the amount of residual disturbance, (c) the presence of other similar vascular lesions, (d) the underlying provocative disease, and (e) the general condition The amount of residual paralysis of the patient is not so important in integrating these facts with the rest of the picture and in estimating the risk Here, again, mature judgment based upon adequate experience is as important in making these judgments as any laboratory or clinical criteria

Renal Disease —The association with renal disease both with and without cardiac involvement is common. The case should be well studied with special attention to the total urmary output, to any changes in blood chemistry, to the degree of azotemia, to any existing edema, and to any other associated condition. Again, one's best guides are experience and mature judgment in integrating the observations, in measuring the risk, and in taking the proper preparatory precautions.

Pulmonary Episodes -- Embolic phenomena are very frequent in the lungs, the lungs are also very susceptible to infection Commonly, both of these forms of disease are combined Large consolidations are less common than scattered Because of these facts, the facility with which bronchopulmonary edema may appear suddenly is a serious and dangerous matter. This danger becomes much magnified when the necessity for intravenous alimentation is present The danger of overloading the circulation with a sudden influx of fluid, when heart reserve is at a minimum, must be avoided Therefore, one should give a small amount at a time and give it Episodes, nevertheless, will occur and confound us even when the patients are under the most expert observation Operation in such individuals is so risky that it ought many times be refused

Blood Chemistry Determinations—Determination of the degree of an associated azotemia is very important in establishing the gravity of disease and of the operative risk in many conditions. This has special reference to all forms of renal disease, to cardiovascular disease in general, and in acute coronary seizures in particular. They are also of value in hepatic parenchymal disease, both because of the liver lesion itself and because of any secondary kidney effects (e.g., hepatorenal syndromes). Whenever possible any deviation from the normal should be corrected before any

operation is undertaken. Unfortunately, however, this is possible to a very limited degree only, if at all

In conditions associated with intestinal obstruction, various grades of azotemia are commonly present and should be interpreted as a measure of the length of time for which the obstruction has existed. Usually no preoperative measures are possible because of the immediate dominating necessity for the relief of the obstruction. The clinically established fact is, however, that the successful release of the obstruction is followed by a spontaneous return of the azotemia to the normal. In patients who are dehydrated, parenteral glucose in saline in sufficient quantity should be given preoperatively and continued, in bad cases, throughout the operation

#### Diabetes

Except in very marked cases, the additional preparation needed for this factor is not much. The diet is not cut down too extensively and whatever glycosuma or hyperglycemia is present is better adjusted with appropriate amounts of either simple or protamine insulin as the occasion demands. In severe diabetics, there is no objection to and, possibly, some advantage in permitting a slight glycosuma to remain. Nevertheless, there is no objection either in the severe cases or in the milder cases to having the patient completely sugar free. There is never any difficulty with this group of diabetics either before or after operation.

When acidosis is present, or in bad diabetics, the preparation takes longer, and sometimes careful jockeying of diet and insulin is necessary before the patient is in satisfactory condition for operation. It seems better, as indicated previously, to content oneself with reducing the glycosuma to around 0.5 per cent, but any acidosis should be eliminated entirely. With good medical cooperation, I have never had a patient who could not finally be brought into satisfactory condition.

## Preoperative Chemotherapy

In all patients the attempt should be made to minimize or avoid postoperative bacterial infection by the use of penicillin and the sulfa group of drugs, preoperatively, locally in the operative area at the conclusion of the operation, and postoperatively

Certain toxic effects of the sulfa drugs have been reported in the literature which are important from the point of view of the cardiac mechanism French and Weller<sup>2</sup> and Dozzi<sup>2</sup> have reported an interstitial myocarditis, rich in eosinophil cells Fortunately these occur rarely

#### Postoperative Care

In all patients and especially in elderly and/or handicapped patients who have undergone any large-scale type of operation, it is important that the care carried out before operation for any of the various complicating or associated disabilities be continued in the immediate postoperative period, in order to continue its good effect and to forestell and counteract the additional injury and/or physiologic disturbance by which the operative procedure was necessarily followed Such complications as cardiac, renal, pulmonary etc. should receive the appropriate attention they need The following are especially important.

Postoperative Hypoproteinemia. —A state of negative nitrogen balance exists for varying periods after operation The important factors include (1) anesthesia (2) a major surgical procedure with operative manipulation of deeply situated viscera and tissues, (3) a brief period of starvation, (4) shock, fever, vomiting and the presence of injured tissues.1

The major portion of the protein loss occurs during the first four or five days after operation and, ordinarily, this brief period of protein deprivation or limitation is well tolerated, and the vast majority of patients recover without any special attention to the temporary abnormality

In all other patients in accordance with the degree of the deficiency the length of time it has existed, the nature of the operation, and so on, the deficiency should be calculated and roplaced as in the preoperative preparation, of which the postoperative therapy is only a continuation, with some intensification of the program.

Postoperative Authenia -It has been noted clinically that following major surgical operations of various types there is frequently a rather prolonged asthema Leriche has referred to this syndrome, which cannot be defined clearly as 'maladic postoperatoire," and ascribed it to generalized disturbances of the sympathetic nervous system. This form of asthenia has been encountered, perhaps, most often after operation upon the pancreas-pancreatic asthenia (Whipple"), and less often upon the gallbladder and liver

or after severe destructive disease. Concerning all of these forms of postoperative asthema, further investigation is necessary. But it is interesting to speculate upon the possible role of any postoperative nitrogen loss in this connection the quantity of tissue protein lost may not be large, it might be sufficient enough to account for the symptoms

#### Summary and Conclusions

Modern surgery has achieved its great successes because of (1) a more profound knowl edge of the pathogenesis and mechanism of discase processes, (2) the resultant changes in the normal physiologic processes and (3) a better appreciation of the role of independent and/or resultant associated abnormalities or disease which commonly complicate the essential lesion for which surgery is contemplated

The important associated abnormalities include (1) protein deficiency states and hypoprotememia. (2) anemia (3) the various forms of circulatory and cardiorenal disease including embolic lesions in the brain, lungs etc. and (4) diabetes These extraneous factors increase in frequency and severity with the increasing age of the patient the presence of a malignancy and the severity of the surgical lesion. This has stimulated a greater understanding of the necessity of properly preparing patients for the large scale operations which today are commonly necessary There is a better understanding of the subject of anesthesia, better training and better technical ability marked by courage upon the part of the operating surgeons, and a better understanding of the postoperative period and of more efficient postoperative care plus the addition of modern methods, including blood and plasma transfu mon and the use of predigested proteins (hydrolvantes)

12 East S7th STREET

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## SOME OBSERVATIONS ON TUMOR OF THE ACOUSTIC NERVE

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(From the Neurological and Neurosurgical Services of the Mount Sinai Hospital)

In THIS communication only selected features of the problem of acoustic neuroma will be emphasized. To the reader familiar with Cushing's classic monograph on the subject it will be evident that little can be added to his lucid and thorough study of nineteen years ago. However, it seems worth while to repeat and underscore some of the more subtle points which tend to be forgotten and thus provide a source of unnecessary controversy. In addition, some features of the problem not mentioned in Cushing's book will be presented briefly.

The material presented is comprised of most of the proved cases of acoustic tumor admitted to the Mount Sinai Hospital in the past twelve years. This includes 40 odd cases, of which 42 have been selected as suitable for presentation. The diagnoses were established either at operation

or autopsy

The classic history of tinnitus and diminution of hearing over an extended period of time followed by vertigo and cerebellar symptomatology is too well known to be reviewed here cases under discussion it was the rule that auditory symptoms preceded all others, although rarely this was not the case Cushing stated that "when the maugural symptoms of a growth, obviously situated in the angle, have another sequence with secondary acoustic symptoms, the diagnosis must remain uncertain until the lesion is exposed " One symptom, also noted by Cushing, which was presented by at least 3 patients, is of considerable importance because of its susceptibility to misinterpretation, namely, motor twitchings of the affected side of the face, eyelid, In 1 patient in our series this was interetc preted as an indication of a cortical focus, leading to the conclusion that the case was one of tumor of the hemisphere Cushing stated "Irritative symptoms referable to the facial have been more frequently recorded than is commonly supposed " It is noteworthy that in his case number 22 a mistaken diagnosis of Jacksonian epilepsy was made on that basis

The ages of the patients at the time of admission ranged from 17 to 65, and were distributed as follows

10-20	1 (17 years)
20-30	3
30-40	11 )
40-50	12 }33, or nearly
50-60	10 ) 80 per cent
60-70	6

Cushing's youngest patient was 21 The majority in his series were in the fifth decade of life

## Involvement of the Fifth and Seventh Cerebral Nerves

Next to the eighth cerebral nerve the fifth and seventh are the most frequently affected in this condition, yet the relative importance of the involvement of each is a continued source of discussion and misunderstanding In the 42 cases studied the sensitivity of the ipsilateral corneal reflex was noted in 40 instances A reduction of the reflex was noted in 18 instances and its disappearance in the remaining 22 In other words. the corneal reflex was reduced or absent in 100 per cent of the cases in which it was examined Objective evidence of involvement of other sensory functions of the fifth nerve was less frequently observed Thus, in 25 per cent, sensation on the face was judged normal In 1 case it was markedly diminished, in 10 cases it was slightly diminished, often limited to the mucous membranes, in 2 instances it was doubtfully lowered, in 18 cases it was moderately though definitely diminished Consequently, it is evident that even if the "doubtfully and slightly reduced" cases are included, at least 25 per cent of the patients in this series display normal sensation on the face judged by objective testing, even though the corneal reflex may be affected ing stated that "attention should be drawn to the that in a few patients the loss of the corneal reflex was the only demonstrable evidence of trigeminal involvement. The most delicate objective evidence of a trigeminal involvement is unquestionably the lowering of, or the loss of, the corneal reflex on the affected side, and a normal corneal sensitivity was retained in only 4 of the 30 patients in whom the condition was carefully noted on the history "

Motor disturbances of the nerve were noted only three times, but this is of no significance since it is not likely that evidence of motor involvement was looked for in every case. Cushing noted deviation of the jaw to the affected side in 12 of his 30 cases, and always in conjunction with marked sensory involvement.

In sharp contrast to the frequent occurrence of sensory fifth involvement, which in the case of the corneal reflex reached 100 per cent in this series, is the relative rarity of significant asymmetries of facial innervation. Thus, 12 cases

displayed no facial asymmetry whatever, 13 showed "questionable" or "suggestive" weakness 9 showed "slight" weakness, and only 7 revealed a definite facial weakness. In other words, the aggregate of normal innervation, "suggestive," and "slight" facial weakness amounts to 83 per cent of the total cases showed a significant facial weakness. It is of further interest, moreover, that in the 7 cases comprising this group, the weakness displayed in 3 instances was not a clear-cut, lower motor neurone paresis.

In some cases a disorder in the sense of taste on the antenor aspect of the tongue was more noteworthy than the facial weakness. Thus in 1 case in which no facial asymmetry was apparent, a suspicion of agousia was noted on the same side as the auditory disturbances. In 4 of the 13 "questionable" or "suspicious" cases of facial weakness there was a definite agousia. These findings suggest that taste sensitivity is a more subtle indicator of the seventh nerve involvement in these cases than is motor activity

Cushing's observations on the subject of facial innervation are in keeping with these findings Whereas he found that 19 of the 30 patients in his series revealed some degree of facial weakness, he added that "in the majority of the cases the paresis was little more than an inconspicuous asymmetry shown in the lower facial muscles a planing out of the nasolablal fold apparent only during expressional movements This is remarkable in view of the fact that the nerve must often be pressed upon within the canal further remarked "The nerve may be elongated in its course to an amazing degree without producing any palsy whatever It normally should measure only about 10 mm but in Case XV, for example, it was 50 mm in length and though flattened to almost paper thinness, the patient showed but very slight expressional weakness of the lower face '

In the writer's expenence these remarks are repeatedly ignored or forgotten During discussions about a possible diagnosis of acoustic tumor one repeatedly hears the objection But there is no seventh nerve involvement!" The findings of the series herein reported confirms Cusling's observation that striking involvement of the facial nerve is a rare phenomenon in tumor of the acoustic nerve.

#### Pyramidal Tract Involvement

Cushing noted that "as a rule (the reflexes) were equally active on the two sides, though in 8 the homolateral reflexes were the more active with an occasional suggestion of clonus at the ankle and in these cases, also there was a sug

gestive dorsal toe response on the same side." In the Mount Sinai series ipsilateral hyperreflexia was noted in several instances, sometimes with a defective toe response and, sometimes, with weakness. Less frequently the hyperreflexia was contralateral. In the majority of instances no asymmetry of reflexes, whatever, was noted. Presumably the greater frequency of ipsilateral than contralateral hyperreflexia is due to pressure of the contralateral pyramidal pathways (above the decussation) against the rim of the foramen magnum.

#### Miscellaneous Observations

Spinal Fluid Protein.—No mention of this occurs in Cushing's monograph. In this series the spinal fluid protein was noted in 20 cases, in all of which it was pathologically increased. The lowest value was 64 mg per cent, the highest was 500 mg per cent. The protein in 14 out of 20 spinal fluid examinations, or in 70 per cent, measured botween 100 and 200 mg per cent.

Blood Pressure—Lamiting the definition of arternal hypertension to individuals whose systolic pressure is over 140 mm and/or whose diastolic pressure is over 00 mm, 12 of 37 individuals showed hypertension. However, 8 of the 12 had borderline hypertension according to this definition and there is, consequently, no evidence that hypertension is found more frequently in accounter tumor than in the general population of this age group

Electroencephalographic Fundings —Variable electroencephalographic tracings were reported on the patients in this series, ranging from normal records to others suggesting focal lexions in the hemispheres. In general pathologic electroencephalographic tracings tended to be non specific and were reported as consistent either with epilepsy or with lexions affecting the third ventricle, as for example internal hydrocephalus due to tumor of the posterior fossa

#### Surgical Aspects

The operations performed on these patients consisted either of simple enucleation of the contents of the capsule or of intracapsular enucleation followed by the removal of all or part of the capsule A controversy still exists concerning the relative ment of each procedure introduced the practice of total extirpation in 1922 and later the device of "uncapping" the Horrax and Poppen advocate cerebellum this method 2 In their hands there is no question of preserving the facial nerve they actively curette the internal auditory meatus so that facial paralyses occur in virtually 100 per cent of the cases afterward they perform nerve anastomoses which they declare function well after about a year

Although they acknowledge a higher operative mortality and admit the disadvantages of facial palsy, they feel that the possibilities of recurrence after simple enucleation and the difficulties in performing secondary operations Cushing, on the other justify this approach hand, tended to adhere to his more conservative procedure of simple enucleation although he conceded the temptation to remove the capsule Yet, he added, "the procedure cannot be unreservedly recommended, as it was in so doing that the hemorrhage occurred which led to the operative complications in case VIII and XIX and the ultimate death of these patients, and in case XXIX to a widespread injury of all the adjacent nerves" In reviewing the matter in 19323 he stated, "I have repeatedly, in years gone by, after a series of favorable cases, some of them with near total extirpations, suddenly been confronted by a fatality from being overradical and have then dropped back to a more conservative attitude, only to have the same cycle repeated" That he did not share the opinion of some others regarding secondary operations is indicated by his further remarks "In the average case, if the pressure effect of the tumor can be so far overcome by an intracapsular excavation as to permit a subsidence of the choked disk and thus to save vision, one may well be content, and should a secondary operation for recurrence ever be necessary, it need not be particularly dreaded "

Actually, he reported several cases in which he performed successful secondary operations as well as others who developed no recurrences, despite the fact that the capsule had been left behind

The experience of the Mount Sinai series agrees closely with the above impressions Simple intracapsular enucleation carried a lower mortality as well as a very much smaller incidence of facial paralyses than did intracapsular enucleation followed by removal of all or part of the capsule. In the cases where all of the capsule was removed, facial paralysis occurred in every instance. In 10 cases where part of the capsule was removed, facial paralysis resulted in 6 instances. Recurrences of large tumors occurred within a year in 4 instances of simple enucleation, but in 4 other cases treated in the same manner, no recurrences had been noted in four, six, seven, and ten years, respectively

It is difficult to explain these discrepancies in the further history of acoustic tumor following simple intracapsular enucleation, but that recurrences do not occur in some instances might be an argument in favor of a procedure which spares the facial innervation. The psychologic effect of a facial paralysis is as important as, if not more important than, the possibility of a recurrence. Again to quote Cushing "The mere lengthening of life is not a desirable basis on which to estimate end results unless the life has been made better worth living"

35 East 64th Street

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### **BIRTHS SET NEW RECORD IN 1947**

There is every indication that the number of births in the United States in 1947 will exceed the 3,440,000 mark set last year, and will thus establish a new all-time high record

Through May of the current year there were, according to provisional figures, about 1,572,000 births as against approximately 1,116,000 in the corresponding period of 1946, an increase of about 456,000

babies, or more than 40 per cent

The extraordinary record for 1946 was due very largely to the unusually high birth rates in the second half of the year. Even in May last year, instead of the usual seasonal decline in the birth rate, the rate increased sharply and continued upward at an accelerated pace during the summer months. Again, in place of the normal drop in the birth rate in the fall of the year, the curve for 1946 continued to climb

without interruption until the very end of the year, reflecting the effect of the rapid demobilization of our armed forces after the close of the war in the summer of 1945

Unquestionably the 40 per cent excess for the first five months of 1947 will be whittled down as the year progresses, but even if the number of births in the last seven months of the year remains at the level of that for May, the record for 1947 will materially exceed that for 1946

It may well be that 1947 will hold the record for numbers of births for some time to come. In any case, the marked drop in the marriage rate for the first five months of the current year as compared with last, foreshadows a drop in the birth rate in 1948—Metropolitan Life Insurance Company Statistical Bulletin. July. 1947

#### THE TREATMENT OF EARLY SYPHILIS WITH PENICILLIN AT BELLEVUE HOSPITAL\*

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ALTHOUGH the treatment of early syphilis with penicillin was inaugurated on a fairly large scale in November, 1943, the statistical data of the results of treatment do not yet mye us the information needed for an authoritative statement on the optimum plan of therapy due to a number of reasons, chief of which are the chronicity and relapsing nature of the disease

As is well known, the evaluation of any new spirocheticidal agent in the treatment of syphilis requires years of trial and a prolonged follow up of patients before any final judgment can be made Even with the most careful observation and a sustained follow up of patients, statistics on the results of rapid treatment for early syphilis cannot be taken at their face value, because of the difficulty in distinguishing between infectious relapses and reinfections Unquestionably many of the so-called failures of rapid treatment for early syphilis are actually reinfections. Never theless, until we have more scientific means of differentiating between relapses and reinfections. it is unwise to attempt to distinguish between them in making statistical analyses. Consequently statistics to date are viriated by an unknown number of reinfections.

With the use of penicillin, additional difficul ties have been encountered in evaluating the results of different rapid treatment schedules because of the varying content of commercial penicillins over the past three years. Treponema pallida are not used in the bioassay of penicillin Only when the commercial penicillins were fractionated and the various crystalline products were tested against Treponema pallida was it discovered that fraction G was a more effective antisyphilitic weapon than any of the other avail able fractions The early commercial penicillins were believed to contain large amounts of fraction Subsequently, with changes in the method of growing the mold, the commercial penicillus were found to contain larger amounts of fraction K than G It is fairly cortain that the penicillins high in fraction K were much more effective against syphilis than when fraction K alone was used but the fact remains that we are forced to compare various schedules of penicillin therapy with no exact knowledge as to the relative merits of many of the penicillins used.

It was not until June 1946, that crystalline G penicillin was produced in sufficient quantities for large scale use in the treatment of early syphilis. Beginning July 1, 1946, at Bellevue Hospital under the direction of the Subcommittee for Venereal Diseases of the National Institute of Health, we started four different schedules of therapy for early syphilis, using the same lot of penicillin G for all patients. Today it is possible to give only a tentative report on the results of a six months follow up of the patients treated with these four schedules, but within another year we should have information that will be more valu able than our present report which deals largely with the results of therapy when varying lots of commercial penicillins were used

#### Schedules of Treatment

Since December, 1943, we have used nine dif ferent schedules of rapid treatment for early syphilis using peniculin alone or penicullin in combination with arsenoxide and/or bismuth of the treatment schedules were assigned to us by the Subcommittees for Venereal Diseases of the National Research Council or the National Institute of Health Unfortunately, owing to the shortage of penicillin during the war, the earliest schedules of therapy assigned to us called for the smallest amounts of penicillin. Therefore the series of patients followed-up for the longest periods were treated inadequately best treatment schedules used by us were started less than eighteen months ago Nevertheless, the results of the various treatment schedules are revealing and of definite value in spite of the differences in the periods over which patients have been observed

Table 1 gives the plan of treatment in each of the nine series of patients, the number of patients treated in each group, the number of patients followed up and the results of treatment up to March 31 1947 Only those patients who have been observed for at least six months after the completion of one course of treatment are in cluded in the table All of the patients treated in the nine series had darkfield positive early

Presented at the 141st Annual Meeting of the Medical Society of the State of New York, Buffalo Panel Discussion on Syphilia Section to Dermatology and Syphiliador Friday, May 9 104".

Added by grants from the Office of Scientific Research and Development and the United States Public Health Service

TABLE 1 -PLAN OF TREATMENT IN THE NINE SERIES OF PATIENTS

Series Number	Amount of Penicilin and Dosage	Number Treated	6 Months or More	- Follow up 2 Years or More	To March 31, 1947	Satisfactory Status	Unsatusfactory Result
1	November 26, 1943-June 30, 1944 10,000 units every 3 hours for 60 dones (600 000 units of sodium pencil lin)	881		249 (65 <b>4</b> %)		136 (54 6%)	113 (45 4%)
2	July~November, 1944 40,000 units every 6 hours for 30 doses (1 200 000 units of sodium penicil lin)	687		444 (64 6%)		(56 7%)	192 (43 3%)
3	November, 1944-December, 1945 20,000 units every 3 hours for 60 doses daily in jections of 0.04 Gm arsenoxide for 8 days (1,-200 000 units of penicillin and 0.32 Gm arsenoxide)	1,146		239	712 (total) (62 1%)	498 (70%)	214 (30%)
4	August, 1945-July 30 1946 600 000 units calcium penicillin in beeswax and peanut oil daily for 8 days (4 800,000 units)	802			529 (60%)	450 (85 1%)	70 (14 9%
5	March-July, 1946 40 000 units every 3 hours for 60 doses daily in- jections of 0 04 Gm ar- senoxide for 8 days, 5 injections of 0 12 Gm metallic bismuth (2,400,- 000 units of penicilin, 0 32 Gm arsenoxide, 0 6 Gm metallic bis- muth)	233			182 (78 1%)	164 (90 1%)	18 (0 9%)
6	July 1-September 30 1946 40,000 units penicillin G every 3 hours for 60 doses (2 400,000 units crystalline penicillin G)	76	63 (85%)			58 (92%)	5 (8%)
7	July 1-September 30, 1946 26,666 units peniculun G every 2 hours for 90 doses (2,400 000 units crystalline peniculun G)	76	59 (80%)		,	58 (98 2%)	(1 8%)
8	July 1-September 30, 1946 80,000 units penicillin G every 3 hours for 60 doses (4,800,000 units crystalline penicillin G)	83	68 (82%)			62 (91 2%)	(8 8%)
9	July 1-September 30, 1946 53,333 units penicillin G every 2 hours for 90 doses (4 800 000 units crystalline penicillin G)	93	74 (80%)			72 (97 3%)	(2 7%)

syphilitic lesions when treatment was started In the time allotted, it is impossible to give a

In the time allotted, it is impossible to give a detailed analysis of these nine groups, but I would draw your attention to the fact that, in spite of the variables already mentioned, these series, with the exception of the last four, represent relatively large numbers of patients followed-up for sufficient time to have genuine significance. The differences in the percentages of satisfactory results between the first three schedules of therapy and those used later with more adequate amounts of penicillin are statistically significant

#### Discussion

From the data given in Table 1 it is apparent that the treatment of early syphilis with 1,200,000

units of commercial penicillin in eight days is inadequate. Even when daily injections of 0.04 Gm of arsenovide for eight days were added to 1,200,000 units of penicillin, poor results were obtained. This may be due in part to the quality of the penicillin used, much of which was probably high in fraction K. Nevertheless, it is advisable to give more than 1,200,000 units of penicillin in eight days for the best results in the rapid treatment of early syphilis.

Good results were obtained with the use of 2,400,000 units of penicillin in seven and a half days (Series 5, 6, 7) One of these schedules (number 5) combined 0 32 Gm of arsenovide and 0 6 Gm of metallic bismuth with 2,400,000 units of penicillin Most of the 182 patients followed-up in this group have been under observation for

a year or more, which is a longer period of posttreatment observation than has as yet been possible in the penicillin G series. Nevertheless, it is doubtful whether the addition of arsenoxide and bismuth is necessary, because the series receiving 2 400,000 units of peniculin G alone (Series 6 and 7) have had just as good results for a six months' follow-up period as were obtained with a similar amount of penicillin with the addition of arsenoxide and bismuth Furthermore, most of the so-called failures in Senes 5 to 9 were probably reinfections To prove my contention that they were reinfections would necessitate giving the case histories of each of the so-called unsatisfactory results This would require more time and space than I have The following brief case histones of the unsatisfactory results in Sones 6 and 7 will serve as typical examples.

#### Treatment Failures

In the following case reports the treatment schedule used was 40,000 units of penicillin every three hours for 60 doses (2,400,000 units of penicillin G)

Case 1—C H a negro man, aged 25 was first treated for secondary syphilis from August 2 1046 to August 9 1046 The quantitative kahn test was 256. It fell to 3 on December 5 1046 On December 30 1046, it was 32 at which time the patient had a small darkfield positive chancre inside the meatus. He also had genorrhea and secondary lesions on the trunk and extremities which were darkfield positive. He had sexual relations with M. W following his original treatment M. W, has contact, was treated at Bellevue Hospital for darkfield positive secondary syphills on December 10 1046 The impression was reinfection.

Case 2 — A. C a negro man, aged 27 was treated for zeropositive primary sphills from August 19 1946, to August 27, 1946 The quantitative Kahn test was 123. On October 10 1946 it was 22 at which time he was found to have a darkfold positive chancre at a different site from his original chancre. The patient admitted sexual relations with B M the first week after his discharge from the hospital B M. his contact, was found to have secondary sphills on October 11 1946. The patient was retreated from October 19 1946 to October 27 1946 and was seronegative two months later The impression was reinfection.

Case 5—M B a negro woman, aged 24, was treated for secondary syphills from August 30 1946 to September 7, 1946 at which time her quantita tive Kahn test was 2 048. The Kahn test on December 5 1946 had fallen to 32. On January 20 1947 it had neen to 256 and she was found to have a generalized macular papular rash. She admitted regular relations with her friend, A. W., with whom she had sexual relations prior to her original treatment and resumed sexual relations two weeks after her treatment. The impression was a probable reinfection.

Case 4.—H. B a negro woman, aged 19, was first treated for secondary syphilis from September 17, 1916 to September 25 1916 at which time her quantitative Kahn test was 1 024 The Kahn test on December 19, 1946 was 64 and on February 21, 1947, it was 128 She returned on February 27, 1947, at which time she had darkfield positive secondary lesions. She admitted regular exposures, following her original treatment with her husband who was found to have darkfield positive secondary lesions on February 29, 1947 The impression was reinfection

Case 5—B W a negro woman aged 23 was first treated for secondary syphills from September 20 1946, to September 28, 1946 The quantitative hahn test was 128. The Kahn test fell to 3 on Docember 5 1946 On February 3, 1947 it was 256 and the patient was found to have secondary lesions which were darkfield positive. She had had regular sexual relations since her original treatment with her husband, C W., who was found to have secondary syphilitic lesions on February 3 1947 The impression was reinfection.

In the following case the schedule of treatment was 28,666 units of penicillin every two hours for 90 doses (2,400,000 units of Penicillin G)

Case 6—Mc. S. a negro man, aged 22 was treated for seropositive primary syphilis from August 6 1046 to August 14 1046 The quantitative Kahn test was 16 at the time of first treatment. On January 8 1047 he returned with a new darkfield positive chancer at a different site from the original one and his Lahn test was negative He admitted numerous exposures. The impression was reinfection.

If we disregard attempts to distinguish between reinfections and relapses, the data given in Series 6 to 9 favor injections of penicillin G every two hours for 90 doses rather than every three hours for 60 doses. But the results so far indicate that nothing is gained by giving more than 2 400 000 units of penicillin G, provided individual doses are given every two or three hours.

#### Penicillin in Beeswax and Oil

Of greater interest than the results of rapid treatment with ponicillin dissolved in water are the results of treatment with daily injections for eight days of 600,000 units of calcium penicillin in beeswax and peanut oil (Series 4) Penicillin in beeswax and oil can be given in outpatient clinics or physicians' offices Our data show that 85 1 per cent of 529 patients followed up for nine months or more have satisfactory results following treatment with penicillin in beeswax and oil Half of the "failures" were probably due to reinfections, but, disregarding attempts to

distinguish between reinfections and relapses, the results of this treatment for a similar follow-up period compare favorably with the results obtained by giving arsenovide, fever, and bismuth for the rapid treatment of early syphilis at Bellevue Hospital. The results shown in Series 4 not only justify the use of penicillin in beeswax and oil for the treatment of early syphilis but also make it desirable for the treatment of patients who will report regularly on an ambulatory basis

I do not have the time to report on the results of retreatments of patients who relapsed or were reinfected A detailed study of these cases is of interest

Suffice it to say here that, although we have treated a number of patients four times, we have no evidence that anyone is penicillin resistant.

One patient who was retreated three times with increasing amounts of penicilin after his original treatment for early syphilis still has a quantitative Kahn test of 64 more than six months after his last retreatment, but his spinal fluid findings which were originally positive have become normal

So far we have found no patient treated for early syphilis with positive spinal fluid findings which failed to become normal after one or more courses of penicillin

## Summary

In concluding I would like to emphasize again that we do not yet know the optimum plan of penicillin therapy for early syphilis. Enough information is available, however, to prove that penicillin in adequate dosage is superior to any other antisyphilitic agent. When penicillin is dissolved in water individual injections should be given every two or three hours for a total of 2,400,000 units. Giving more than this amount in a seven- or eight-day period seems unnecessary

Penicilin in beeswax and oil has proved effective in the treatment of early syphilis when given in daily doses of 600,000 units for eight days Possibly equally good results could be obtained with smaller amounts. Also, it may well be found in the future that injections of penicillin in beeswax and oil can be given less frequently over a longer period of time with satisfactory results. Much remains to be learned about the optimum period of treatment, but, in the meantime, we are fortunate in having an effective, relatively nontoxic weapon added to our armamentarium in the treatment of syphilis.

## SCIENTIFIC EXHIBITS 1948 ANNUAL MEETING

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W P Anderton, M.D., Secretary

## TREATMENT OF LATE ACQUIRED SYPHILIS OTHER THAN NEUROSYPHILIS

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(From the Department of Dermatology and Syphilology University of Buffala School of Medicine)

MUCH data on the treatment and outcome of treatment of early syphilis is available in the literature, since it is quite easy to determine the effects and efficacy of treatment on this form of syphilis Recent literature has numerous refer ences to various rapid methods of treatment. employing arsenicals, bismuth compounds, and antibiotics There are several guides which may be used in determining the efficacy of this treatment such as the healing of local lesions, disappearance of spirochetes from the local lesions, and observations on the titer of blood Wasser manns, or other serum tests. However, when one seeks information on the effects of treatment upon late syphilis, these guides are not available. In the case of latent syplulis since a serum Wasscrmann reversal is an inconstant phenomenon and there are no local lesions which one may observe, the only basis for judging the officacy of treatment is by following patients over a period of many years to see whether they develop any serious late complication of the disease.

It is desirable to compare patients observed for years and treated with various treatment sched ules with patients who have not received treatment to determine the ultimate benefits and the proper amount of treatment to employ One can observe in benign late syphilis, such as mucocu taneous gummata, osseous gummata, or visceral gummata, the healing of the local lesions, but this phenomenon is no criterion of cure nor an indication that more serious late complications such as a cardiovascular syphilis, will not develop the case of cardiovascular syphilis one can deter mine with some degree of accuracy, whether in the instance of simple nortitis, treatment prevents more serious complications such as aneurysm or aortic maufficiency, but when frank saccular aneurysm or nortic insufficiency has developed it is difficult to determine how much benefit is derived from specific antisyphilitic treatment.

There have been relatively few studies done upon the outcome of untreated early or latent syphilis and ultimate outcome of treated latent syphilis. The studies done on treated latent syphilis have all been on the effects of arsenical and heavy metal therapy, since the antibiotic treatment of syphilis is of such recent date that

enough time has not elapsed to determine definitely its value in the treatment of late syphilis other than neurosyphilis. Observations to date on the effects of antibiotics have been on their results in the healing of benign late syphilis. In spite of the inadequacies of long term studies on late syphilis we will attempt to present the known facts regarding proper treatment of the various phases of late acquired syphilis other than neurosyphilis

#### Latent Syphilis

By the term latent syphilis we mean syphilis in which there is neither symptoms nor physical signs of the disease other than positive serum tests. We exclude from the category of latent syphilis those patients in whom the spinal fluid examination is positive. This group we classify as asymptomatic neurosyphilis, and they will not be considered in this presentation

Recently we have studied and published data on a group of patients with latent syphilis who had been observed for a period of ten years or more 1 These patients were divided into two groups 100 patients received forty or more injections of an antisyphilitic drug and 69 received less than this amount. Those who received forty or more treatments were considered as hav ing been treated adequately They were com pared with the group that received less than forty injections of an antisyphilitic drug. The 100 nationts who received forty or more injections were divided into subgroups to determine the effects of varying amount of arsenical drugs and bismuth compounds on the ultimate clinical and serologic outcome From this study we were able to determine, with some degree of accuracy, the ultimate outcome of untreated or poorly treated latent syphilis and the effectiveness of varying amounts of treatment in the prevention of late serious complications of syphilis. The study demonstrated that in both treated and untreated latent syphilis there was a decided tendency of blood serum tests to fluctuate over a period of years. It also demonstrated that treatment had only slight effect upon the blood serum It was shown that in the case of properly treated latent syphilis the blood tests were of no progonatic value. Those patients in whom the blood remained positive following treatment did as well chincally as those in whom the blood be-

Presented at the Idiat Annual Meeting of the Madical Bockety of the State of New York, Buffalo Section on Der matelogy and Syphilology Panel Discussion on Syphilis Friday May 9 1947

came negative This study indicated clearly that in latent syphilis one should not continue to treat patients because blood tests are positive

We were able to show that arsenical drugs were more important in the prevention of late cardiovascular syphilis than were bismuth compounds, and that the optimum amount of treatment consisted of twenty to twenty-nine injections of an arsenical compound in combination with approximately forty injections of a heavy metal treatment than this amount did not improve either the clinical or serologic outcome. It was found that in patients who received this amount of treatment or more, only 1 9 per cent developed a serious late complication. Of the patients who received little or no treatment, 20 to 25 per cent developed a serious, late cardiovascular complica-There were also other less serious complications This demonstrates the effectiveness of proper treatment in the prevention of cardiovascular syphilis

Our studies, in general, agree with those of Diseker, Clark, and Moore,2 who observed 926 cases of latent syphilis for five years or more These authors believe that even less than the above treatment is adequate. In view of our findings, we, at the present time, recommend that patients with latent syphilis be treated with conventional doses of bismuth and arsenical com-These are to be given in courses of approximately ten weekly injections of an insoluble bismuth compound and eight weekly injections of an arsenical compound Approximately four such courses should be given Rest periods of two months may be permitted between courses, since short rest intervals appeared to have no effect upon the ultimate clinical outcome this amount of treatment has been given, no further treatment should be administered, regardless of the serum outcome Patients should then be examined at six- to twelve-month intervals for years, and special attention given to the cardiovascular system

We hesitate to speak of cure in latent syphilis, but, as far as we know, most of our adequately treated patients were cured in a chinical sense, masmuch as no signs or symptoms of syphilis, other than a positive blood test, presented themselves in a period of more than ten years. It may be that adequate treatment completely cures most latent syphilis and the persistence of a positive blood test is of no more significance than a positive Widal test following recovery from typhoid fever. We are unable to present any useful data on the effects of penicillin on latent syphilis. Stokes et al., while treating benign late syphilis with penicillin, found some improvement in the reagin titer in 50 to 60 per cent of 96 late.

cases <sup>3</sup> Ten per cent of their patients developed completely negative blood tests. This does not, however, give any indication as to the ultimate clinical outcome of these patients since they were not followed long enough. Data on the ultimate clinical outcome of patients treated with varying amounts of penicillin will not be available for many years.

## Benign Late Syphilis

In the authors' experience, the treatment of spinal fluid negative benign late syphilis with arsenicals and bismuth compounds produces as good a result as previously described under latent We could not determine from our observation on such patients that mucocutaneous or osseous syphilis predisposed to cardiovascular syphilis We believe benign late syphilis should be treated much the same as late latent syphils. There is some controversy as to whether arsencals should be employed in the treatment of gummatous syphilis of the liver It has been our practice to rely mostly upon iodides and bismuth in treating such patients Hahn,4 however, recently has presented data on 25 patients with gummatous syphilis of the liver and states that there is no evidence that hepatic damage due to syphilis predisposes to hepatic damage due to arsenicals He warns that the use of arsemcals in syphilis at the hilum of the liver might possibly give rise to a therapeutic parado, and thus produce portal thrombosis He believes that the presence of ascites contraindicates arsenical therapy

Stokes et al have recently reported upon the action of penicillin on lesions of benign late syphilis. These authors report that gummatous manifestations of skin, mucosa, and bones yield with striking rapidity in most instances and Tucker reported equally good results in producing the resolution of cutaneous, mucosal, and osseous gummata, and reported that hepatic gummata also respond well 5 They recommended a dose of at least two million units None of these penicillin-treated patients have been followed for a long period of time, so it is impossible to predict whether the penicillin given in treatment of late gummatous syphilis will prevent the development of cardiovascular syphilis at a later date know that small amounts of arsenical and bismuth drugs will produce rapid healing of late gummatous syphilis, but that the amount of treatment necessary to produce such healing is not adequate to prevent the development of other serious complications at a later date fore, do not at this time recommend the simple penicillin treatment of late benign syphilis feel that if this substance is used, the patient should also be given adequate treatment with arsenical and bismuth compounds

Olansky recently has reported Jarusch Herx heimer reactions from relatively small doses of penicillin. It has been noted repeatedly that in early syphilis at least 50 per cent of patients have reactions varying from mild to those with fover as high as 105 F. Olansky noted that as little as one thousand units of penicillin per injection could produce severe reactions in late syphilis. He concluded that ponicillin in any dose may give reactions and recommended that any patient with late syphilis who is to be given penicillin therapy receive bismuth therapy first. We are in accord with the observations of Olansky.

#### Cardiovascular Syphilis

We recently have gathered data on 177 cases of cardiovascular syphilis to determine how many had received adequate treatment either during the early stages of their syphilis or during the latent period. We were also interested in determining the effect of treatment on well-advanced cases of syphilitic aortitis, where the physical and x-ruy findings left little doubt as to the diagnosis. We are aware that many of the cases of latent syphilis, which were included in our previous study, were actually mild cases of syphilitic aortitis which are not diagnosable either by physical or x ray findings.

We believe that we have demonstrated that the proper treatment of these mild cases usually prevents development of nortic insufficiency or saccular ancuryam. This previous study did not include diagnosed syphilitic nortitis and in this study we wished to determine whether treatment of advanced nortifis prevents further progression. We were also interested in the race and sex incidence of the various forms of severe cardiovascular syphilis and the duration of the syphilis before cardiac involvement was demonstrable.

We divided out 177 cases into two groups, depending upon the type of aortic involvement Group I, consisting of 64 patients, had simple syphilitic aortitis The diagnosis was made upon physical and x ray findings Group II consisted of 113 cases of aortic insufficiency and saccular ancurysm. Thirty of the patients had both

#### Syphilitic Aortius

The average age group of the 64 patients was 46.8 years. There were 19 of the patients who knew when they had acquired syphilis, and the average duration from the early phases of the disease until a diagnosis of syphilitic aortitis was made was 21 7 years. Only 4 of the patients gave a history of having had forty or more injections of an antisyphilitic drug during the early or

latent phases of the disease. None of them had had as much treatment as we recommended previously for routine use in latent syphilis Eleven others had sporadic treatment, the average amount being four injections of an arsenical drug and four injections of a heavy metal. The other 40 patients had received no treatment during the early or latent stages of the disease Fifty-six of the 64 patients were under our observation for longer than one year These 56 were observed an average of 54 years. During this period 16 of them progressed from simple syphilitic aortitis to either aortic insufficiency or aneurysm The other 48 patients still had syphilitic acrtitis at the time of the last examination. The 16 patients who developed nortic insufficiency or aneurysm received little or no treatment during the period when they had frank syphilitic acrtitis average amount of treatment these patients received was 7.7 injections of a heavy metal and one injection of an arsenical drug Most of the other 48 patients were under antisyphilitic treatment for much of the period of observation believe, therefore, that proper anthryphilitic treatment of diagnosable syphilitic acrtitis prevents or slows down development of aortic insufficiency and ancurysm

#### Aortic Insufficiency and Saccular Aneurysm

There were 113 patients who had acrue insufficiency, succular angurysm, or both patients were observed for an average of about 29 years. There was considerable variation Several were observed ten years or more We were unable from our data to determine definitely what effect, if any, specific antisyphilitic treatment had upon prolonging the life of these It is our feeling that those who were patients diagnosed early and received treatment did better than those who were not treated. We do not believe that antisyphilitic treatment had much effect upon those who were diagnosed late in the course of their cardiac disease. We feel that advanced aneurysm of the aorta or aortic in sufficiency with decompensation is a problem for the internist rather than for the syphilologist

Many of these patients are still alive and under treatment. The average age of this group was 49 7 years. There were 48 patients in the group of 113 who knew when they had acquired syphilis, and the average time from the early phases of the disease until a diagnosis of severe cardiovascular syphilis was made was 21.8 years. Only 3 patients of the entire 113 gave a history of having had forty or more injections of an antisyphilitid drug Twenty others had some previous antisyphilitic treatment, the average amount was 4.5 injections of an arsenical drug and 7.8 injections of a heavy metal.

There was a decided preponderance of late, serious cardiovascular syphilis among negro men This was particularly true in saccular aneurysm Cardiovascular syphilis was next most common in white men and least common in white women It is our belief that hard manual labor, as performed by many of our negro patients, predisposes them to severe forms of cardiovascular syphilis and, therefore, we feel that patients who have syphilitic aortitis should not perform hard manual labor

## Comment on the 177 Cases of Cardiovascular Syphilis

We were unable to determine accurately what effect antisyphilitic treatment had upon prolonging the life of our patients with saccular aneurysm Our studies indicate, and aortic insufficiency however, that treatment of uncomplicated syphilitic aortitis often does prevent development of the more serious cardiovascular complications Padget and Moore state that antisyphilitic treatment of patients with saccular aneurysm and aortic insufficiency prolongs their life At best, though, such treatment adds only one to two years to life expectancy It is evident, therefore, that patients with syphilis should receive treatment before cardiac involvement is demonstrable We and other authors have shown that in most instances severe forms of cardiovascular syphilis may be prevented either by the proper treatment of early or latent syphilis None of our patients with cardiovascular syphilis had proper treatment during the early or latent period of their disease

We believe that simple syphilitic acrtitis should be treated much the same as latent syphilis. but that the treatment should be prolonged over a period of years We are unable to give the exact optimum amount of treatment but believe steady treatment should be given for at least two years followed by one course of treatment yearly for a total of five years Patients who are then symptom free should be kept under observation Once aortic insufficiency or aneurysm has developed, specific antisyphilitic treatment must be used cautiously Treatment should consist of alternating courses, started with heavy metals weekly for eight toten weeks in full doses, followed by arsenical drugs in one half to two thirds of the Because of the danger from reacusual dose tions, the best arsenical drug to employ at the present time appears to be mapharsen. There are fewer reactions which might be damaging to a cardiac patient with this drug than with the other arsenicals

No regular schedule of treatment can be given as this varies with each individual patient

depends upon their cardiac reserve and how well they tolerate treatment During periods of decompensation they should not be treated with antisyphilitic drugs but should be treated as are other types of decompensated heart disease Nothing is known at the present time of the value of antibiotics in the treatment of cardiovascular Jausch-Herzheimer reactions syphilis been reported in patients with caridovascular syphilis receiving penicillin treatment. If this substance is to be used, patients should be prepared adequately with heavy metals beforehand

## Summary and Conclusions

- Serum tests for syphilis cannot be used as a guide in the treatment of latent syphilis patients whose tests remain positive following treatment do as well clinically as those whose tests become negative
- Proper arsenical and bismuth therapy of latent syphilis usually prevents serious, late complications
- Arsenical drugs are more effective in the treatment of latent syphilis than heavy metal compounds
- Optimum treatment consists of twenty to twenty-nine injections of an arsenical compound and about forty injections of a bismuth compound
- 5 Benign late syphilis should receive the same treatment as latent syphilis
- Proper bismuth and arsenical therapy of syphilitic acrtitis prevents or slows down the development of aortic insufficiency or aneurysm
- Bismuth and arsenical treatment may prolong, somewhat, the life of patients with aortic insufficiency and aneurysm
- Patients who have late syphilitic cardiac disease seldom have had adequate antisyphilitic treatment during the early or latent period
- Among patients with syphilis, late syphilitic cardiac disease is most common in the negro man, next most common in the white man, and least common in the white woman

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#### TREATMENT OF NEUROSYPHILIS\*

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IT IS obvious that the primary goal in treating an infectious disease must be the destruction or arrest of the invading micro-organism in the shortest period of time without injury to the pa tient. In addition, one would like to reverse the clinical manifestations which have occurred in the course of the disease. But this is not always possible because frequently the pathologic process has been so destructive that restitutio ad intearum is impossible. In such cases terminating an infection cannot in itself restore function Let most authors who report therapeutic results in neurosyphilis use, as the standard of success. the clinical improvement of the patient without realising that clinical manifestations may possist although the inflammatory syphilitic process has been arrested That the activity of the infection and the clinical manifestations of the disease do not run parallel is shown in cases of asymptomatic neurosyphilis where the infection may be very active and continue for many years without mani festing itself in neurologic signs or symptoms Finally, clinical improvement of the patient may be only transitory and not indicative of the total arrest of the process.

All these facts emphasize the need for more objective criteria for the success or failure of treatment than a reliance on clinical manifesta tions alone

What then should be the standard for deter mining the effectiveness of our therapeutic measures? For more than twenty years we have demonstrated and stressed that the spinal fluid findings are the only reliable guides as to the activity and character of the infectious or degenerative process. However this holds true only if the spinal fluid examination comprises the cell count, total protein determination, colloidal gold and complement fixation test, and if all the tests are considered as a whole. Furthermore, all these tests must be quantitatively standardized so as to give accurate and reproducible results.

What are the criteria of activity of the syphili tic process as mirrored in the spinal fluid findings? Based on our past experience in the follow-up of parctic patients who were successfully treated

of paretic patients who were successfully treater

Presented at the 141st Annual Meeting of the Medice
Bodely of the State of New York, Buffalo, Section on De-

Presented at the 141st Annual Meeting of the Medical Society of the State of New York, Buffalo Section on Der matclory and Syphilology Fanci Discussion on Syphilis, Friday, May 1647.

\* Alded by grants from the Office of Scientific Research and Development and the United States Public Health Service. by malaria therapy as demonstrated by their survival for more than fifteen years, we have emphasized that the cell count is the most important aid in determining the activity of a syphilitic process in the central nervous system. As a rule lymphocytosis is the first abnormality to disappear in the spinal fluid after successful treatment as it is the first to appear after infection of the central nervous system. The increase in protein, abnormal colloidal curves and specific tests for syphilis may persist for longer periods, even though the pathologic process has been arrested

Because of such discrepancies between the rapid drop to normal of the cell count in successfully treated patients as compared with the gradual decline or fluctuating values obtained in the other tests confusion has anson in the literature with regard to the effectiveness of treatment as reflected in the spinal fluid syndrome

Within the past few years, however, through the initiative of the New York State Department of Health laboratory (Dr. Maillard in charge of the New York Branch) quantitative complement fixation tests and quantitative colloidal gold tests have become available. With the ald of these new quantitative tests it becomes apparent that there is a strict parallelism between the activity of the process and all the spinal fluid tests.

As an illustration we present two case histories Case 1 -The patient was a 26-year-old negro woman whose first knowledge of syphilis dated back to 1942 when a positive Wassermann reaction of the serum was found by a local medical doctor. She was given 80 neoarsphenamine, 34 mapharsen and 2 bismuth injections until March 1944. A positive spinal fluid syndrome for syphilis of the central ner your system was found in the Bellevue Outpatient Department on April 17 1944 A recheck of the spinal fluid findings on May 16 1944 revealed identical results. No neurologic abnormalities were present and the patient therefore was classified as having asymptomatic neurosyphilis. The patient was given 2 000 000 units of penicillin 20 000 units every three hours for 100 doses. At the end of treatment the cell count protein values and colloi dal gold test showed a slight drop Six months after treatment the cell count total protein and col-loidal gold tests were normal. However a recheck six months later showed abnormal values for these tests, and one month later the abnormalities were still more pronounced Therefore the patient was retreated with 8 000 000 units of penicillin 50 000 units every three hours, for 160 doses Since then

TABLE 1—RETREATMENT AFTER FAILURE WITH 2,000,000 UNITS PREVIOUSLY TREATED WITH 30 INJECTIONS OF NEOARSPHENAMINE AND 34 INJECTIONS OF MAPHARSEN

Test Num- ber	Date	Blood Wassermann	S F Wassermann	Colloidal Gold	Total Protein	Pandy Test	Cells
1 2	4/17/44 5/16/44	4+ 4+	4+ 4+	4444 3321	25 25	<sub>F</sub> <sup>+</sup> T	100/3 98/3
	May, 1944	-2,000,000 Units	Penicillin				
3 4 5 6 7	5/29/44 7/31/44 11/21/44 5/22/45 6/4/45	100* 84 66 62 62	4+ 4+ 9* 27 41	1221 1110 50** 107 122	21 12 18 27 25	0 0 0 0 F T	15/3 2/3 7/3 70/3 332/3
•			000 Units Penicillin				
8 9 10 11 12 13	7/9/45 9/11/45 12/17/45 3/11/46 7/2/40 10/28/46	53 67 44 41 27 33	27 19 15 12 10 8	104 97 58 53 45 55	24 14 16 13 16 13	0 0 0 0 0	41/3 2/3 1/3 3/3 2/3 1/3

<sup>\*</sup> Titered in units

all the tests, including, the quantitative complement fixation test, have been constantly improving Table 1)

It should be noticed that the reversal of the spinal fluid findings indicating renewed activity of the process occurred more than six months after termin-This would indicate that a ation of treatment waiting period of more than six months is required to evaluate the arrest of the process by tests of the spinal fluid In the follow-up of malaria-treated patients we found that only about 4 per cent of the patients had a similar relapse more than six months after treatment. So far, the same rate seems to prevail in our penicillin-treated patients

Case 2 — A 36-year-old patient with general paresis had deteriorated markedly over a period of several months before admission He was first subjected to malaria treatment. Spontaneous arrest of fever occurred after the seventh bout of fever and. therefore, the patient, was given three intravenous typhoid vaccine injections with satisfactory febrile He then received ten daily injections of

mapharsen, 006 Gm each. The spinal fluid syndrome showed signs of activity one year after termination of this treatment and the clinical status of the patient had only moderately improved Quartan malaria with nine fever bouts, followed by ten daily injections of mapharsen, 0 06 Gm., resulted in a slight improvement of the spinal fluid findings then subjected to a course of forty intramuscular injections of a pentavalent arsenical (Solvarsin) spite of this, the spinal fluid examination indicated persistence of an active syphilitic process and the patient, therefore, was given 9,000,000 units of pencillin, 40,000 units every three hours for 225 doses Since then all tests of the spinal fluid show a marked decrease which has now continued for two years He has had a normal cell count since March, 1945, but clinically he has never attained his preparetic level (See Table 2)

It would be desirable to report on the therapeutic results which were obtained by various methods of treatment of neurosyphilis

TABLE 2—Penicillin Success After Malabia Failure Secondary Styphilis at Age 18—Routine Treatment for 18 Months

Test							
Num-		Blood	8 F	Colloidal	Total	Pandy	
ber	Date	Wassermann	Wassermann	Gold	Protein	Test	Celis
1	9/8/42	4+	4+	5555	000	4+	90/3
	Septembe	r, 1942—Tertian M	alaria (7) and Typh	old (8) and Mapha	rsen (10)	2.1	,
2	10/5/43	4+	4+	5555	80	4+	39/3
	October, 1	1943Quartan Mal	aria (9) and Mapha	rsen (10)	00	**	00/0
3	5/6/44	4+	4+	5554	72	0.1	11/8
	May, 1944	4-20 Pentavalent	Arsonicals	7007	12	8+	11/0
4	6/22/44	4+	4+	5555	••		0.10
		-20 Additional Per			56	3+	6/3
5	1/18/45	4+	4+	5555			(0.10
ő	3/1/45	4Î*	170*	180**	150	4+	48/3 70/3
		459,000,000 Unit		200	188	4+	10/5
7	8/24/45	44	90	178	***		15/3
8	3/80/45	82	70	176	104	4+	11/3
8 9	5/3/45	19	60	178	92 112	**	11/3
10	6/24/45	15	41	174	104	4.7	10/8
11	9/20/45	7	22	179	74	7.7	8/3
12	12/6/45	5	13	168	74 51	37	5/3
13	2/28/46	8	22	177	54	3T	4/3
14	5/8/46	4	8	164	57	iΞ	4/3
10 11 12 13 14 15	12/16/48	4	5	140	54 57 48 46	i∓	11/3 10/3 8/3 5/3 4/3 4/3 4/3 8/3
16	3/8/47	•	8	114	46	- 1	8/3

<sup>\*</sup> Titered in units

The figure given represents the sum of readings in all 10 tubes by new Lange method

<sup>\*\*</sup>The figure given represents the sum of readings in all 10 tubes by new Lange method

TABLE 3 - Dorage of First Treatment in Millions of Oxford Units and Number Retreated

								Four						-	
	Total	Two	R*	Three	R	Four	$\mathbf{R}$	and Half	R	Five	$\mathbf{R}$	Bix	R	Nine	R
Asymptomatic	31	15	3	1	1	δ	1	3	0	0		7	0	0	
Meningovasoula	46	5	2	9	2	8	2	8	0	0		19	2	0	
Tabes dorsalis	53	5	2	19	3	8	1	3	1	2	0	16	0	1	0
General parcels	41	0		1	0	33	1	3	0	8	•	9	3.	0	
Taboparesis	22	Ó		1	0	11	1	3	Ó	i	0	0	0	ō	
Total	193	25	7	81	5	54	7	17	1	8	2	57	5	1	0

Indicates failures
 Showed satisfactory spinal field changes but were retreated to determine the effect of retreatment on clinical manifestations.

TABLE 4.-LENGTH OF FOLLOW UP IN SATISFACTORY CARES

				N.	onthe -		
	Total	Blx	Twelve	Eighteen	Twenty Four	Thirty	Thirty-Six
Asymptomatic	26	4	18	6	5	3	ó
Maningovascular	38	7	8	6	14	2	1
Tabes dorsalis	45	10	11	6	15	3	à
General paresis	35	3		7	13	Ō	i
Taboparesis	21	5	8	4	Ö	2	i
Total	105	31	33	29	53	16	3

ever, I will limit my comments to the effect of pencillin in neurosyphilis. For the purpose of comparison I will give the figures reported by me with Drs Thomas and Wexler in a previous paper on the rapid treatment of neurosyphilis with malaria and chemotherap. With this type of treatment the percentage of success in all types of neurosyphilis varied from 74.2 to 88 5 per cent the average being 85 9 per cent. In this series there were 298 patients who were followed-up from six to forty-seven months

How do these figures compare with results ob-

tained with penicillin therapy?

At Bellevue Hospital, we have treated 250 patients having neurosyphilis with penicillia alone, using penicillin dissolved in water, given intramuscularly every three hours. The total desage of penicillin used in these cases varied from 2,000 000 to 9 000 000 units, given in dosages varying from 30 000 to 40,000 units per in jection every three hours (Table 3) riod of treatment varied from nine to twentyeight days The spinal fluid was examined before treatment and every three months after treatment for the first year, then every ax months thereafter The longest period of observation was thirty-six months (Table 4) to be expected, the largest percentage of relapses following treatment occurred among those who received less than 5 000 000 units.

Of the 250 patients treated, only 226 completed their treatment more than six months ago and 33 have been lost from further observation, so that only 193 have been followed up for more than six months, 135 of these have been followed for a year or more and 73 for two or more years.

Of the 103 patients followed up for more than six months (Table 5) 85 per cent now have an inactive spinal fluid which compares favorably with the figures given for a similar group of patients treated by combined malaria and chemotherapy

I have not attempted to evaluate the results of

treatment by describing the clinical response. Many of the patients had marked clinical improvement So far as we can determine this differed in no respect from that following malaria therapy But I wish again to emphasize that we treat syphilis for the purpose of eradicating the infection. If this is accomplished function of damaged nervous tissue may or may not improve according to the localization of the process and degree and extent of the damage. Thus for any scientific evaluation of treatment we must discover to the best of our ability, whether or not we have arrested or destroyed the invading organisms. If at the same time there has been an im provement of function we, as well as the patient can rejoice, but this alone does not afford as ob-

Reference
1 Dattner B, Thomas E, W, and Wexler G; Am. J
Syph., Gonor & Ven. Dis. 25; 265 (May) 1944

jective a criterion for the arrest of the infection as

does the spinal fluid syndrome.

TABLE 5 .-- RESULTS OF FIRST TREATMENT

Asymptomatic Meningovascular Tabes dorsalis	Total 31 46 53	Batislactory 26 38 45	Indefinite 0 0 1	Fallure 5 8 7	Failures Retreated 5 8 7
General paresis Taboparesis	41 22	35 21	8	î	î
Total	198	165 (85%)	1 (1%)	27 (13%)	37

### THE SEROLOGIC TESTS IN PENICILLIN-TREATED SYPHILIS

CHARLES R REIN, MD, New York City

(From the Skin and Cancer Unit of the New York Post-Graduate Medical School and Hospital, Columbia University, and the Division of Scrology, Army Medical Center, Washington, D(C)

PRACTICING physicians frequently are faced with the problem of how to evaluate or interpret serologic reports obtained from the laboratory in determining the presence or absence of a syphilitic infection. They are often disappointed when serologic tests remain positive for several months following penicillin therapy. There are, however, several factors which influence the length of time required to attain seronegativity.

### Factors in Seronegativity

1 Stage of Disease—The older the disease the longer spirochetes have been present and the longer it takes for the body cells to stop forming reagin. As a rule, patients with secondary syphilis require more time to acquire seronegativity than patients with seropositive primary lesions.

2 Immunologic Response of Individual Patients—Some patients with syphilis develop more antibodies or reagin than do others after the same type of stimulus. The former patients usually require more time to attain seronegativity.

3 Serologic Titer—As a rule, patients with high serologic titers at the onset of therapy may require more time to attain seronegativity than those with relatively low titers

4 Sensitivity of the Serologic Procedure—The more sensitive the serologic test the longer it will take to attain seronegativity. When a serologic battery consisting of tests with varying sensitivities is employed, negative reactions may be obtained with less sensitive tests long before the more sensitive tests become negative

6 Type of Test—Certain types of tests may remain positive long after other tests have become negative, even though they may be in the same relative range of sensitivity

6 Treatment Schedule—The amount of pencilin, the type of pencilin, and the length of time required to administer that amount of treatment may also affect the length of time to attain seronegativity. As a rule, the higher the total dosage of pencillin, the greater the percentage of the "G" friction and the longer the period of time during which the treatment is administered, the shorter the time required to attain seronegativity

Presented at the 141st Annual Meeting of the Medical Boolety of the State of New York Buffalo, Section on Dermatology and Syphilology, Panel Discussion on Syphilis Friday, May 9, 1947

It must be pointed out, however, that there are many variations to the above factors and no set rules can be made to determine or anticipate the length of time required to attain seronegativity Thomas believes that patients who continue to have persistent, strongly positive serologic reactions nine months after rapid therapy should be retreated as a precautionary measure 1. He emphasized the fact that one should not expect rapid reductions in serologic titers in such patients after retreatment It has been observed that some patients may remain seropositive, particularly when treatment is started during the stage of secondary syphilis, for as long as two years before reversal to seronegativity If retreatment is instituted within the first year and that patient subsequently becomes seronegative, the clinician is at a loss to know whether that reversal is due to the additional treatment or whether he would have become negative if the retreatment had been withheld Certainly such patients should not be classified as "treatment failures" in evaluating the efficacy of penicillin in the treatment of syphilis

## Serologic Differentiation Between Relapse and Reinfection

With the introduction of various forms of rapid treatment for early syphilis, particularly penicillin therapy, many more patients are attaining serologic and clinical cures earlier than hereto-Such patients are candidates for reinfections and it is not an infrequent occurrence to find patients reinfected with their own spirochetes This type of reinfection was very aptly called "ping-pong" syphilis The individual acquires syphilis extramaritally and, after the development of the primary lesion, infects his marital He receives adequate penicillin therapy and may attain a rapid clinical and serologic cure During this time his wife has been incubating the spirochetes and reinfects him with his own spirochetes on subsequent sexual exposure

The onterna for indisputable reinfection are quite rigid and, unfortunately, the patients are not observed at sufficiently frequent intervals to satisfy all of these requirements. It is, therefore, often quite difficult to determine whether the patient has developed a new infection or if there has been a relapse of the old infection.

At the Army Medical School we have had considerable experience with the serologic follow-up

of patients with penicillin treated early syphilis A battery of serologic tests was performed with serums of such patients at daily, weekly, and monthly intervals. From our observations we feel it is possible to distinguish between relapse and reinfection by carefully conducted quantitative serologic studies at frequent intervals Following peniculun therapy in patients with early syphilis, there is usually a progressive reduction in serologic titer. In reinfection the patient usually attained and maintained complete seronegativity followed by the development of a dark field positive, seronegative lesion at a new site. Shortly afterwards such patients developed seropositive reactions with rapidly increasing In treatment failures or relapso there was noted a sudden increase in serologic titer followed in about one month by clinical evidence of a mucocutaneous relapse in the majority of in stances. If penicillin-treated patients would be subjected to serologic examinations at weekly or monthly intervals, it might be possible to predict a clinical relanse about one month before there is any clinical evidence, by a progressive increase in scrologic titer on repeated examinations

It is of utmost importance therefore to edu cate patients of the great need of reporting to physicians for serologic and clinical examinations at regular monthly intervals for at least one year following the completion of penicillin therapy

Many patients who are classified as clinical relapses are most likely reinfections. It is not fair to consider such cases as treatment failures when the majority of them may actually be reinfections. For every reinfection classified as relapse there is a reduction of 2 per cent in the 'cure rate' in Indicating the efficacy of that particular treatment schedule

### Penicillin Therapy in Concomitantly Acquired Gonorthea and Syphilis

With the introduction of penicillin the phy sician now has at his disposal a therapeutic agent which is efficacious in the treatment of gonorrhea and syphilis When penicillin was adopted by the Armed Forces as the standard treatment for gonorrheal infections it was anticipated that a concomitantly acquired syphilitic infection would be masked by the penicillin and many reports of this type have appeared in the literature most instances the patient acquired syphilis con comitantly with the gonorrheal infection iscuous patients however, may acquire syphilis immediately prior to or soon after becoming in feeted with generation. The amount of peni cillin (usually 200 000 to 400 000 units) which is adequate for the cure of gonorrhea is definitely inadequate for the concomitant avphilitie in-

fection In such patients the following may occur

(a) Abort.—If the patient received penicillin very early in the course of the gonorrheal infection and the syphilis is only of a few days durition, that relatively small amount of penicillin may be sufficient to abort or cure the syphilitic infection. This has been corroborated by animal experiments where small amounts of penicillin administered a few days after infection were sufficient to affect a cure

(b) Mask—If the concomitant syphilitic infection is a few days older, the same amount of penicillin may prevent the appearance of the primary or secondary lessons. In such instances the only evidence of a syphilitic infection is the development of positive serologic tests for syphilis several weeks or months following treatment of the genorrheal infection.

(c) Delay—In still older infections the penicillin therapy will tend to delay the appearance of the early cutaneous manifestations for several months after the disease has been acquired

Some investigators 1, 1 have observed the oc currence of chills, fever, and malaise developing early in the course of penicillin therapy for gonorrheal patients who also have a syphilitic infection. They believe these symptoms indicate a Hery helmer reaction due to the rapid destruction of the spirochetes, the incidence and severity of the reactions depending upon the extent of the spirochetal invasion It has been suggested that the following be done whenever penicillin therapy is instituted for gonorrheal infections (1) thorough examination for any clinical evidence of syphilis and the performance of a serologic test prior to the administration of therapy, (2) observations should be made for the occurrence of chills, fever and malaise accompanying penicillin therapy (3) repeated clinical and serologic rechecks at monthly intervals for six months following ther-If at any time during this period there is any clinical or serologic evidence of syphilis additional adequate penicillin therapy should be administered

It has been estimated that approximately 75-000 soldiers were separated from the United States Army with positive serologic tests for syphilis. Many of them presented no clinical or anamiestic evidence of syphilis. They did how over receive penicillin therapy for an acute gonor rheal infection at some time during the preceding several months. It is quite possible that they may have acquired a concomitant syphilitic infection and the relatively small amount of penicillin (200 000 to 400 000 units) served to mask or abort the appearance of the early syphilitic lesions. It is suggested therefore that patients

who develop positive serologic tests following penicillin therapy for gonorrhea be considered as having acquired a concomitant syphilitic infection, and that additional antisyphilitic therapy be instituted

### Conclusions

Carefully conducted quantitative serologic examinations are of definite value in the control of follow-up of penicillin-treated syphilis

As a guide of response to treatment

- As a means of differentiating between serologic relapse and reinfection
- In predicting an impending clinical relapse
- As a means of detecting masked syphilis following a concomitantly treated gonorrheal infection

### References

- 1 Thomas, E W Am J 202 30 317 (1946) 2 Leifer, W, and Martin, S P JA.M.A. 130 202 (1946) 3 Kromer, S Cutler, J C, and Levitan, S Ven. Dis Inform 27 174 (1946)

### VETERANS CONVALESCENT HOSPITAL

New York State has established, at Mt Mc-Gregor, one of the finest and most modern institutions for convalescent care of its veterans. All patients are under medical supervision at all times Physical medicine is practiced to further the purpose of restoring the veteran to an employable state of health, or to as close an approach to normal heath as may be attained. To this end, a modern Occupational Therapy Department is maintained, and also physiotherapy facilities are available, consisting of whirlpool bath, short-wave diathermy, ultraviolet lamps, infra red, and bakers Prescriptions for outdoor exercise are carried out carefully and supervised by a competent athletic instructor equipment necessary for diagnostic work is an allable for use of the physician, including x-ray, fluoroscopy unit, electrocardiograph, basal metabolism apparatus, and other usual aids. The medical staff consists of two physicians, five nurses, one physic-therapist, one occupational therapist, and an 1-ray and laboratory technician

The property consists of approximately 1,600 acres, of which 1,200 acres are mostly forest land, with many pleasant trails for use of the patients Nine modern, fire resistant buildings are used for housing the patients, providing accommodations for 650 to 700 patients during the summer months, and 450 patients during the winter Administration building, theater, refectory, chapel, occupational therapy, power house, two dormitory buildings for employees, and residences for eleven families complete the main group of buildings The farm of 400 acres supplies milk and cream from its herd of registered Ayreshires, and eggs, poultry, pork,

and fresh vegetables This entire service is provided at no cost to the

veteran, including transportation to and from his home, and lodging, meals, laundry, and the use of all facilities and equipment

Veterans' Counselor or the Director of the County

Veterans' Service Agency Admittance is obtained by contacting a State

### ALLERGY CONVENTION IN DECEMBER

The American Academy of Allergy will hold its annual convention at Hotel Jefferson, St Louis, Missouri, December 15 to 17, inclusive All physical Al cians interested in allergic problems are cordially invited to attend the sessions as guests of the Academy by registering without payment of fee The program and the scientific and technical exhibits have been arranged to cover a wide variety of conditions where allergic factors may be important Round table conferences will be held on Monday afternoon, December 15, 1947 Advance copies of the program may be obtained by writing to the Charles of American Charles H. Evergence Chairman on Arrangements, Charles H Eyermann, M D, 634 North Grand Boulevard, St Louis, Missouri

### THREE BEST ESSAYS IN THE NATION

The Association of American Physicians and Surgeons, in cooperation with State and County Medical Societies, announces the winners of the annual National Essay Contest for Junior and Senior High School Students for 1947

The three best essays on the subject "Why the Private Practice of Medicine Furnishes This Country with the Finest Medical Care" were written by Miss Jean Downhour, Benchland, Montana, who won the first prize, \$1,000, second prize was awarded to Richard Brandow, Bradford, Pennsylvania, \$500, and the third prize of \$100 went to Miss Bettye

Eccles, Gulfport, Mississippi Honorable mention and \$25 cach was awarded to Naw York, Miss Jean Ritchie, Saratoga Springs, New York, Miss Louise Bekman, Ottumwa, Iowa, and Richard

Renner, Mansfield, Illinois.

## THE VALUE OF SYMPTOMS AND PHYSICAL SIGNS IN THE DIFFERENTIAL DIAGNOSIS OF JAUNDICE

WILLIAM F LIPP, MD, ALFRED R. LENZNER, MD, and AH AARON, MD Buffalo New York

J AUNDICE is a frequent sign of pancreobiliary tract disease. It is essential that the nature and location of the lesion producing the jaundice be recognized if proper treatment is to be instituted. In the light of recent progress in the field of liver physiology with consequent advances in (1) the medical (dietary) treatment of liver disease, (2) preoperative and postoperative care in biliary tract surgery, and (3) the surgical management of malignant disease involving the pancreas and duodenum, the need for accurate diagnosis becomes even more evident.

For clinical purposes, jaundice occurring as a result of lesions in the pancreobiliary tract may be divided on an anatomic basis into intrahepatic and extrahepatic jaundice (known by various terms such as hepatocellular jaundice, parenchymal jaundice, etc.) includes infectious hepatitus, the cirrhoses, and the dystrophies, the management of this group of diseases usually is medical Extrahepatic jaundice, commonly called obstructive jaundice, includes such lesions as common duct stone, carcinoma, and stricture, as a rule, the treatment is surgical.

The differential diagnosis between intrahepatic and extrahepatic jaundice continues to represent a problem in a small but definite group of cases in spite of increasing knowledge of biliary tract physiology Most of the errors in diagnosis occur in the group of patients of middle and past middle life. In recent years many so-called liver function tests have been introduced for the purpose of aiding in the differential diagnosis of jaundice, as well as to assess the degree of hepatic damage Clinical investigation has demonstrated the shortcomings of these laboratory tests Their usefulness is limited by the com plexity and multiplicity of liver physiology, the extensive reserves of liver tissue, and the capacity of the liver for regeneration. Although certain of these procedures have value in supporting a clinical impression the differential diagnosis of jaundice at the present state of our knowledge remains largely a bedside problem Consequently, it is of value to recognize the symptoms and signs commonly associated with the various types of mundice.

### Material and Method

In an effort to evaluate the degree of accuracy of diagnosis in jaundice in a general hospital. the records of 412 patients admitted to the Buffalo General Hospital during the period 1936 to 1946 with the presenting sign of icterus were The patients were admitted on many services and consequently a number of physicians shared in their management. Thus, it is felt that the results of the study represent a generally fair picture of the management of jaundice at the general hospital level. In each case the causative lesson was within the pancreobiliary tract. patients with so-called hemolytic laundice were excluded from the study In most instances the diagnosis was confirmed through surgical intervention, biopsy, or postmortem examina tion. However, in the majority of cases of infectious hepatitus and in some cases of cirrhosus the diagnoses were necessarily clinical.

In the present portion of the study an attempt is made to determine the relative diagnostic worth of such clinical factors as age, sex, duration and depth of jaundice, pain, chills and fever, history of previous attacks, digestive symptoms, alcohol and other liver poisons, weight loss, splenomegaly, palpable gallbladder, physical characteristics of the liver, ascites, angioma, and color of the stool The distribution of cases is shown in Table 1

TABLE 1 -- DISTRIBUTION OF CARES

	Cases	Percentage
Intrahepatic Hepatitis—60 Cirrhosis—91 Dystrophy—24	175	42 5
Calculus	152	36 9
Carcinoma of pan-	63	15 3
Biliary carcinoma* Stricture	1 <u>8</u>	3 6 1 7

The designation billary eardnoms refers to malignant lesions other than neoplasms of the pancress, such as car chroms of the galibladder carrinoms of the bile ducts and metastatic carrinoms.

#### Results

Age.—The distribution according to age is shown in Table 2. Eighty-six point six (80.0) per cent of the patients with hepatitis were under forty years of age and were equally distributed over the second third and fourth decades while 78 per cent of those with dirrhosis were over forty years and were similarly distributed over the fifth sixth, and seventh decades. The cases of dystrophy were scattered through all age groups. Common duct stone was

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Presented at the Islat Annual Meeting of the Medical Society of the State of New York, Buffalo Section on Gastroenterology and Proctology May 7 1947

TABLE 2 -AGE\*

Under 40	41-50	51-60	61-70	70+
52	Я	2	2	1
	25	23	17	ē
		9	4	1
	27	44	32	28
2	6	18	29	8
0	2	5	8	0
4	0	3	0	0
	52 20 10 21	52 3 20 25 10 0 21 27	52 3 2 20 25 23 10 0 9 21 27 44 2 0 18 0 2 5	52 3 2 2 20 25 23 17 10 0 9 4 21 27 44 32 2 0 18 29 0 2 5 8

\* In all tables figures indicate number of cases

much more frequent in the later decades (86 1 per cent over forty). The great majority (96 8 per cent) of patients with carcinoma of the pancreas were above forty years, while 87 3 per cent were fifty years or older. The cases of carcinoma arising elsewhere in the biliary tract were distributed similarly to those with carcinoma of the pancreas.

When these statistics are examined from the point of view of age rather than the disease, it is found that 75 2 per cent of patients under forty years of age have types of intrahepatic jaundice, and 72 9 per cent of cases over fifty years have forms of extrahepatic jaundice, while from 40 to 50 years the two principal classes of jaundice are about evenly distributed (intrahepatic, 44 5 per cent, extrahepatic, 55 5 per cent)

Thus consideration of the age of the patient has some significance in the differential diagnosis of laundice

TABLE 8 -- Sex

	Men	Women
Hepatitis (60)	30	30
Cirrhosis (91)	59	žž
Dystrophy (24) Calculus (152)	8	16
Calculus (152)	49	103
Carcinoma of pancreas (63)	38	25
Biliary carcinoma (15)	8	7
Stricture (7)	0	7

Sex —The sex incidence is shown in Table 3 As would be expected in infectious disease, there was an equal distribution in hepatitis Cirrhosis showed a predominance of men in the ratio 2 to 1 (men, 64 8 per cent, women, 35 2 per cent) The reverse was true in the cases of dystrophy In common duct stone, women predominated in the ratio 2 to 1 (men, 32 3 per cent, women, 67 7 per cent), while in carcinoma of the pancreas the relationship was reversed, there being 60 3 per cent men and 39 7 per cent women.

Thus, in cirrhosis, common duct stone, and carcinoma of the pancreas a significant sex incidence obtains

Degree —The intensity of jaundice was graded clinically on a 1 to 4 plus scale, as shown in Table 4. This is obviously a gross observation and varies with the examining physician and the interpretation of records. The degree of jaundice generally was considered less in the intrahepatic group, except for the dystrophies, although there were a number of instances of deep jaundice in patients with hepatitis and cirrhosis. In extrahepatic jaundice, the intensity appeared greater when the obstruction was due to a malignant lesion than when it was produced by a common duct stone. Because of rather wide vari-

TABLE 4 -JAUNDICE (DEGREE)

	1+ to 2+	8+ to 4+
Hepatitis (60)	42	18
Cirrhosis (91)	70	21
Dystrophy (24)	7	17
Calculus (152)	121	31
Carcinoma of pancreas (63)	10	53
Biliary carcinoma (15)	3	12
Stricture (7)	1	6

TABLE 5 -JAUNDICP DURATION IN WEEKS

1	2	3	4	4+*
49	7	2	2	0
13	23	10	23	22
12	3	3	4	2
94	26	7	10	15
8	6	12	4	43
1	2	3	1	8
0	0	0	2	5
	13 12	49 7 13 23 12 3 94 26 8 6	49 7 2 13 23 10 12 3 3 94 26 7 8 6 12	49 7 2 2 13 23 10 23 12 3 3 4 94 26 7 10 8 6 12 4

ations, the degree of clinical interus would appear to have limited value in the individual case

Duration —This factor also is subject to a number of variables —Except for cirrhosis, the duration of intrahepatic jaundice was generally one to two weeks, as shown in Table 5 —This was also true in common duct stone, while in extrahepatic jaundice due to malignancy a longer history (four weeks and more) was present in over half of the cases —Although many factors tend to influence the course of jaundice from onset to time of hospital admission, a longer history would suggest either carcinoma or cirrhosis

TABLE 6 -PAIN

	None	Severe	Moderate	Distress
Hepatitis (60)	32	3	15	10
Cirrhosis (91)	84	0	2	5
Dystrophy (24) Calculus (152)	20	2	2	0
Calculus (152)	9	129	14	0
creas (63)	37	5	ĬĨ	10
Biliary carcinoma (15)	12	1	1	1
Stricture (7)	4	2	1	0

Pain —For the purposes of this study, pain was designated as (1) severe, denoting the biliary colic type of pain, (2) moderate, such as "dull", "aching", and (3) distress. It is well known that pain descriptions will vary from patient to patient, depending on the individual threshold, among other factors. The distribution is shown in Table 6

Pain was a much more prominent symptom in extrahepatic jaundice, particularly in the patients with common duct stone where typical biliary colic occurred in 84.9 per cent of cases Pain of moderate intensity was described by 92 per cent patients, while in 59 per cent there were so-called "silent" stones.

In carcinoma of the pancreas pain of varying degrees was present in 413 per cent of the cases. It was severe, simulating biliary colic, in 79 per cent, in 175 per cent there was moderate pain, in 159 per cent distress alone was described. In 7 cases (269 per cent) with pain there was radiation through to the back, "boring" in nature. Thus, 587 per cent of patients with pancreatic malignancy had so-called "painless jaundice". Of the cases with carcinoma elsewhere in the biliary tract, such as the

gallbladder and bile duets, 70 9 per cent gave no history of pain

Pain, variable in type and degree occurred in 46 5 per cent of patients with hepatitis, 77 per cent of those with cirrhoses, and 16 5 per cent of those with various dystrophies. However in only a few instances did the pain in intrahepatuc jaundice (hepatitis, 5 per cent, dirrhoses 0 per cent dystrophy, 8.3 per cent) resemble the colle of common duct stope.

The presence of pain and its nature constitute a significant clinical aid in the differential diagnosis of laundles

Prerious Attacks—The frequency of previous attacks in the group of choledocholithiasis was strik ing enough for special comment. Seventy-six point nine per cent of patients with extrahepatic jaundice due to common duct stone gave a history of one or more previous attacks of billary colic. Of these, 36.7 per centreported jaundice with one or more of the earlier episodes while 27.3 per cent had had a previous cholecystectomy. This has diagnostic value. The only other billary tract diseases under consideration in which recurrent episodes of jaundice might be expected are the cirrhoses and dystrophies.

TABLE 7 -- CHILLS AND FEVER

	Chills at Onset	Fever
Hepatitis (60)	12	26
Cirrhosis (91)	4	21
Dystrophy (24)	0	7
Calculus (152)	70	63
Carcinoma of pancress (63)	4	9
Biliary eardinoma (15)	ī	5
Stricture (7)	2	3

Chills and Fever—These data are presented in Table 7 Except for the cases of bepatitis, the history of a chill was infrequent in intrahepatic jaundice It occurred at the onset in 20 per cent of the hepatitis group In extrahepatic jaundice chills were associated with 50 per cent of the cases of common ductation, while they were uncommon in maliginant obstruction (6.3 per cent)

Fever at the time of admission was 100 F or more in 43.3 per cent of those with hepatitis 23 per cent with cirrhests, 20 I per cent with dystropty 41 4 per cent with choledocholuthasis 14.3 per cent with carcinoma of the pancreas and 33 3 per cent with malignancy arising elsewhere in the biliary tract.

As would be expected, these manifestations are more likely in the presence of infection and acute tusue destruction. The history of chill suggests common duct stone or infectious is patitis.

Digestive Symptoms.—Anorexia and nausea are usual in all forms of jaundice Emesis occurred in 716 per cent of cases having hepatitis 11 per cent having cirrhosis 417 per cent dystrophy; 57 per per cent common duct stones 22 per cent paneres tic malignancy and 6.7 per cent having carcinoma obsewhere in the billary tract.

Thus emeals in the presence of pain might sug gest common duct atone while emeals with no pain or moderate pain might favor the diagnosis of hepetitis or dystrophy Hepatotoxins.—Fifty-six point ax per cent of the patients with cirrhosis gave an sleoholic history while in those with dystrophy 12 per cent used alcohol to excess and 12 per cent were exposed to other recognized liver poisons

TABLE 8 .- Loss of Wright

	None	5-10 Pounds	10 Pound Plus
Hepatitis (60)	59	1	0
Circhoeds (91)	71	6	14
Dystrophy (24)	19	4	1
Calculus (152)	126	4	23
Carcinoma of pancreas (63)	3	5	55
Biliary carcinoma (15)	1	1	13
Stricture (7)	1	3	4

Weight Loss.—The incidence of loss of weight is shown in Table 8. As would be expected, this was more common in the groups with malignant obstruction. Eighty-seven point three per cent of the patients with carcinoma of the pancreas and 86 6 per cent of those with carcinoma arising elsewhere in the billary tract had lost ten pounds and more However 14 4 per cent of the patients with common duct stone and 15.3 per cent of those with cirrhosis also reported marked loss of weight.

Liser—Except in some of the cases of dystrophies and cirrhoses the liver was almost always increased in size. However the variation was so considerable that this sign appeared to have little value in the differential diagnosis. Nodular livers were more common in the chronic affections such as cirrhosis and carcinomatous involvement. Tenderness occurred more frequently in hepatitis (50 per cent) and common duct stone (75 per cent)

Palpable Spilen.—The spicen was felt in 25 per cent of the patients with hepatitis 516 per cent with carrhests 208 per cent with dystrophy, 19 per cent with choledocholithiasis 31 per cent with pancreatic tumors, and 60 per cent of those with carcinoma arising elsewhere in the billiary tract (Table 9) If the intrahepatic types of jaundice are considered as a group spienomegaly was evident in 38.2 per cent of the cases the spicen was felt in only 2.9 per cent of all cases of extrahepatic jaundice

Consequently, the presence of a palpable spleen is an important finding, indicating an intrahepatic type of jaundice.

TABLE 9 -PHYSICAL SIGNS

	Spleen	Gallbladder	Ascites
Hepatitis (60)	15	0	O
Cirrhoeis (91)	47	0	73
Dystrophy (24)	8	Ó	6
Calculus (152)	3	. 9	.0
Careinoma of panereas (63)	2	27	11
Biliary cardinoma (15)	1	Ī	3
Rivieture (7)	1	0	0

Palpable Gallbladder —The gallbladder could be felt in 42.8 per cent of the patients with carrinoma of the pancreas, according to Courvoisier a law (Table 9) In a much larger portion of the cases of pancreatic carcinoma, the gallbladder was found to be greatly distended at laparotomy An enlarged tender gallbladder was noted in a few instances of common duet stone.

A palpable gallbladder, therefore, is a valuable sign of extrahepatic jaundice, usually indicating the presence of carcinoma of the pancreas

Ascites —Free fluid in the peritoneal cavity was demonstrated in 79 1 per cent of the patients with cirrhosis, 25 per cent of those with dystrophy, 17 4 per cent with pancreatic malignancy, and 20 per cent with carcinoma, arising elsewhere in the biliary tract (Table 9)—It is thus a frequent sign of intrahepatic jaundice, although it may occur during the later stages of malignant disease

Angioma —Angiomas were noted in 35 per cent of the patients with cirrhosis. This incidence is low, undoubtedly because it is only recently that they have been looked for. They represent a sign of intrahepatic disease, particularly cirrhosis.

TABLE 10 -- COLOR OF THE STOOL

	Brown	Light Brown	White
Hepatitis (60)	41	18	1
Cirrhosis (91)	79	12	0
Dystrophy (24)	19	5	0
Calculus (152)	116	27	9
Carcinoma of pancreas (63)	2	22	39
Biliary carcinoma (15)	1	10	4
Stricture (7)	2	Б	0

Color of Stool .- The color of the stool in the various forms of jaundice is shown in Table 10 "White" stools were described in 16 per cent of patients with hepatitis, none in those with dystrophy, 59 per cent of those with common duct stones. 618 per cent of those with carcinoma of the pancreas, and in 266 per cent of cases of malignancy elsewhere in the biliary tract Brown stools occurred in the majority of patients with intrahepatic jaundice, as well as extrahepatic jaundice due to The color of the stool of jaundiced patients measures approximately the degree of obstruction Thus the frequency with which complete obstruction occurs in extrahepatic lesions, particularly carcinoma, and the infrequency with which it occurs in intrahepatic jaundice constitute a valuable clinical ındex

### Summary and Conclusions

The value of the churcal picture in the differential diagnosis of jaundice is reaffirmed by the results of an analysis of the records of 412 patients admitted to the Buffalo General Hospital This observation probably reflects the management of jaundice throughout the country at the general hospital level—the level at which a large section of the population is served In the great majority of cases, careful evaluation of such clinical factors as age, sex, pain, splenomegaly, and ascites, among others, will indicate the site and nature of the lesion producing the naundice In spite of improvement in our understanding of liver physiology with the development and application of many tests of liver function, the diagnosis will at the present state of our knowledge be arrived at through bedside observa-Indeed the more useful laboratory procedures may be employed only to confirm the clinical impression, and they will lose what value they possess unless the results are interpreted by the clinician in the light of the clinical picture

Furthermore, as will be reported in another communication relative to the rate of accuracy of diagnosis in jaundice, there will remain a small group of patients in whom the most intensive study over a period of time will fail to demonstrate satisfactorily the causative lesion and in whom surgical exploration will be necessary to avoid overlooking a remediable extrahepatic lesion such as a silent common duct stone or neoplasm

The diagnosis of pancreobiliary tract lesions producing jaundice is made in the majority of instances through careful appraisal of historical evidence and physical findings

### Discussion

Dr Albert F R. Andresen, Brooklyn, New York.—The authors have done a very fine piece of work in studying 412 cases of jaundice from the records of a general hospital, and in addition to their present study we may anticipate a series of articles on various phases of pancreobiliary tract disease which will be of inestimable value to the clinician

I agree with the authors that the differential diagnosis of jaundice, in spite of the many liver and pancreatic function tests which have been devised, is still largely a bedside problem. Some of our most valuable liver function tests cannot be applied in the presence of jaundice, and the very multiplicity of tests shows that as yet no really conclusive ones are available in any case. It has been pointed out by the authors that this is to be expected because of the many functions of the liver, its reserves of liver tissue, and, particularly, its capacity for regeneration of functioning liver cells

The present study shows how valuable such a gathering of statistics of a large group of proved cases can be It demonstrates the importance of a consideration of age and sex in the differential diagnosis of jaundice as contrasted with the relative uncertainty of the degree and duration of jaundice The severity of the pain in extrahepatic jaundice as contrasted with its comparative mildness or absence in intrahepatic jaundice is an interesting observa-The frequent presence of pain, at times even severe, in pancreatic carcinoma should be emphasized, as should the frequent presence of fever and the relative absence of chills The universal complaint of retrostaltic symptoms with frequent vomiting in all types of jaundice is a well known fact, with this study showing that severe pain with vomiting suggests common duct stone, whereas vomiting with little or no prin favors intrahepatic jaundice

The predominant history of alcoholism in patients with cirrhosis agrees with the experience of all clinicians, although as an etiologic factor it is regularly discounted by pathologists. In connection with the discussion in regard to liver enlargement,

it should be pointed out that clinical notes on charts often will describe enlargement of the liver when operation or necropsy will show a liver of normal or even small size. A diagnosis of splenomegaly is also often a deceiving observation, some clinicians per hans being able to feel spleens better than others The authors also point out how frequently an enlarged galibladder though present, is not felt in the presence of pancreatic carcinoma. Observations in regard to the color of the stool are notoriously bad in general hospital cases and white or clay-colored stools may often be caused by the presence of barrum given for an x-ray study

I agree with the authors in their conservative estimate of the value of laboratory procedures in the differential diagnosis of jaundice in their emphasis of the value of clinical interpretation and in their conclusion that often surgical exploration is desir able in doubtful cases in order that curable or remedi able surgical measures be not neglected

#### TUBERGULOSIS PATIENTS REACT WELL TO PURIFIED STREPTOMYCIN

Four New York doctors report that reactions to highly purified streptomycin on long-continued ad ministration are sufficiently low to justify the use of the drug in the treatment of most forms of tuberculocis.

This investigation was conducted under the di rection of the National Research Council Committee on Chemotherapeutics and Other Agents, by Drs Robert F Farrington, Harnet Hull-Smith Paul A

Bunn, and Walsh McDermott.

Writing in the June 21 issue of the Journal of the American Medical Association the investigators point to four general types of toxic reactions to the drug among 16 tuberculous patients histamine or allergic reaction in which pouon is released by the tissues, characterized by flushing, headache, and an abrupt fall in blood pressure, various forms of ana phylaxis or hypersensitivity to the drug neurologic disturbance with occasional deafness and kidney damage.

However in only two of the 16 patients treated for 120 days, was it necessary to interrupt the ad minustration of the drug and it was possible to re-sume treatment eventually in both of these patients.

'On the basis of the present investigation," write the physicians "it appears that the toxicity of highly purified streptomycin is sufficiently low to justify its long-continued administration to patients with ac-tively progressing tuberculosis and other comparably serious infections. Conversely it appears that streptomycin should not be employed in the treatment of relatively benign [mild] infections such as recently developed minimal tuberculosis or chronic brucellosis [undulant fever], until the question of possible late effects resulting from the use of the drug can be determined.'

### INDIVIDUALIZED TREATMENT NEEDED FOR THYROID PATIENTS TO AVERT CRISIS

Patients with a serious and sometimes fatal condition resulting from overactivity of the thyroid gland called 'thyroid storm by four Boeton doctors, should receive individualized treatment directed toward the correction of all recognizable abnor malities

Writing in the July 5 issue of the Journal of the Writing in the suny o mane of the Journat of the American Medical Association, Drs. Janet W MeArthur Rulon W Rawson, J H Means, and Oliver Cope, from the Thyrold Clinic Massachusetts General Hospital state that of a total 2,033 patients with a poisonous thyroid admitted to the wards of the Massachusetts General Hospital in the past

25 years 30 had experienced a thyroid storm.
Our conception of storm, the doctors say "is essentially that it represents the inability of the patient any longer to adjust to the strain imposed by the hyperthyroldism [overactivity of the thyroid glandi

Sixteen of 25 patients who experienced a thyrold storm following surgery died and eight of 11 patients having thyroid storm following medical treatment died.

The most common complication in these 86 patients was heart disease which was noted in 23 pa-tients. "That these complications exerted a significant, often decisive influence on the survival of the patients is clear "state the authors, for of the 12 survivors, whose sverage age was 48 five had complicating decases, whereas among the 24 deaths, average age 49 19 had complicating diseases.

In the majority of patients the physicians were able to determine a precipitating factor which pro-voked the crass in the medical storms the commonest cause was the withdrawal of iodine and in surgical atorms, the crisis usually followed the removal of the

thyroid.

In conclusion the authors point out that since thyroid crisis occurs in patients with severe poisonous thyroids who are undernourished and suffer from serious complicating diseases and in whom medical treatment has been unsatisfactory the occurrence of crisis can be reduced by not operating on such patients until normal thyroid function has been restored in the patient with antithyroid drugs such as thiouracil.

# REPORT OF AN ITCHING DERMATITIS APPARENTLY DUE TO SCHISTOSOMA CERCARIAE

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(Commissioner and Director, Division Communicable Diseases, Westchester County Department of Health)

BEGINNING about the latter part of July, bathers at Interlaken Lake in the Town of Eastchester, Westchester County, New York, began to experience an itching eruption that at first was considered to be the result of insect bites The lesions developed, shortly after bathing, as minute red macules or papules which increased in diameter, in some cases remaining more or less flattened and in others becoming slightly raised In the more extensively involved cases the distribution was irregular but more or less general, except for the face and arms Some of the lesions became quite red, appearing almost pur-The fastigium lasted about three days with more or less discomfort due to the itching. after which the eruption tended to subside during the next few days The itching did not respond to the usual local applications One patient, an adult woman with a very extensive involvement. was hospitalized for relief from the intense irrita-Among the children there was evidence of mechanical injury and mild secondary infection with crusting due to scratching Two or three of the patients mentioned some edema about the eves

The lake in question is part of a multiple apartment development, housing about 1,500 people Bathing is restricted to the tenants Formerly a reservoir for the City of New Rochelle, Interlaken Lake, which is shaped like a V, is a little over a mile long and a little less than 1/4 of a mile at the widest part There is an artificial sandy beach about 100 feet long on the outer shore near the center of the V, with a dock extending out into deep water for the swimmers and a fenced-in pen for young children A short distance from the dock on the side opposite the pen are some boats and the resting place of a flock of waterfowl The waterfowl, which consist of some domestic white ducks and a few wild ducks, together with occasional wild geese, have been more numerous this year than formerly As they are fed by the children, they tend to congregate near the same part of the shore in close proximity to the bathing area

In view of the supposed absence of water itch in this part of the country it was at first thought that the itching eruption was probably due to insect bites. It was generally agreed, however, that it did not resemble mosquito bites nor did there appear, on casual inspection, to be any other insects present in sufficient numbers to account for the trouble

In view of the inconclusive nature of the investigation, and having in mind the possibility of a causal connection with the waterfowl, some snails obtained in the area of the bathing beach were submitted for examination to the Department of Preventive Medicine, New York University, College of Medicine Donald V Moore, who conducted the investigation in the laboratory, discovered cercariae in one of the snails which, when placed on his wrist, produced a typical water itch eruption Two of his associates also developed a dermatitis snails, which were sent by Dr Moore to the Museum of Comparative Zoology at Harvard University, were identified by Dr William J Clench, curator of mollusks, as Physa heterostropha Say Dr Moore was unable to find cercarnae in a pail of the lake water obtained at the bathing beach However, one of the white ducks that was sent to him for examination was found to harbor schistosomes which proved to be Trichobilharzia physellae

It appears probable from the foregoing that the bathers at Interlaken Lake were affected by schistosome dermatitis. This in turn evidently resulted from the presence of some infected waterfowl that have been visiting the lake as well as other collections of water in lower Westchester County in increasing numbers in recent years. It is evident that this condition, formerly associated primarily with the Great Lakes region, is now present in this part of the country. With the increasing influx of waterfowl it is probable that water itch will be encountered with greater frequency hereabouts in the future.

### EMBOLIC OCCLUSION OF THE BIFURCATION OF THE ABDOMINAL AORTA

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(From the medical services of Dr Thomas J Longo Medical Director, Coney Island Hospital)

THE study of thrombo-embolic disease is of the utmost importance today Recent surgical and medical advances in diagnosis and therapy have been remarkable. With the advent of refinements in survical technic and the further development of anticoagulant therapy early recognition of occluave ambolic processes in the larger arterial vessels is imperative

In the past we have seen on our wards classic cases of "rider's embolism in theumatic heart discase with auricular fibrillation. 1 Several have been treated by embolectomy others have been recanalized under medical therapy and with no fur ther embolic processes, have led fairly useful lives

It is our purpose to present the atypical manifestations in which early diagnosis may enable the

institution of early remedial measures.

Up to 1943 when Greenfield reviewed the litera ture 156 cases of thrombosis and embolism of the sorts had been reported.2 He added 5 more cases and Reich \* in 1948 added 10 cases, making a total of 177 reported cases. There is no doubt, however that the incidence is much greater Recovered cases usually are not reported: others (like some of ours) without unusual features are likewise not reported Phillips and Gross point out that atypical cases are frequently overlooked. The classic dramatic onset with sudden, severe pain in both lower extremities followed immediately by objective signs of arterial occlusion offers no difficulty

It is the group of cases with slow onset and apparently gradual occlusion which requires attention We shall present one such case with autopsy find ings and a second case in which early diagnosis was arrived at because of our experience with the first

#### Case Reports

Case 1 -M T, a 40-year-old woman, was admitted on February 17 1944 and died on March 14 1944

Her chief complaint was numbress of both lower extremities of three months' duration coming in transient attacks following emotional stress in-volving both feet legs, knees the lower quarter of both thighs in circular fashion, and the anal region Her legs felt rubbery, the patient felt as though she were losing her legs and was unable to stand or walk. She would, however, do both if she were urged. Her family history was negative except that she was the oldest and favorite child of a family of six siblings. She had always been nervous, irritable and easily aroused to emotional stress. Nine years ago she had an almost complete bilateral cophorectomy She had had rheumatic heart disease since 1921 and auricular fibrillation since 1941

Physical examination on admission revealed a pa tient who apparently, markedly exaggerated her symptoms and demanded sympathy with rewards being offered for such sympathy she did not appear acutely ill. There were evidences of left and right

ventricular hypertrophy Systolic and diastolic murmurs were audible at the apox, the pulmonic second sound was greater than the acrtic second sound The rhythm was totally irregular and the ventricular rate was 96 per minute. The right lower extremity revealed some weakness and a diminished There were no pathologic reflexes. abdominal reflexes were present. No color changes were noted. The numbress in both lower extremities continued, but on February 19 1944 the knes jerks were bilaterally equal and active On February 22 the lower right extremity became cold and painful, and an area of bluish discoloration appeared on the lateral aspect of the right calf. The dorsalis pedis popliteal, and femoral arteries were not palpable on either side Heparmization was immediately instituted. On February 23 the lower right extremity was warmer but the area of bluish discoloration was larger The oscillometric readings were negative at all levels of both lower extremities. The evidences of arterial obstruction in the lower right extremity increased gradually and on Febru ary 26 the patient was accepted for surgery \(\lambda\) ray of the lower extremity on March 4 revealed loss of soft tissue at the apex of the toes and poor detail of the middle phalanges (gangrene of toes) On March 6 a midcalf amputation under refrigeration anesthesia was performed The patient a condition On March 13 signs of condeteriorated gradually solidation were noted at the right lung base, and on March 14 the patient died

The pertinent laboratory findings were tempera ture 100 F to 102 F for three weeks up to the fourth postoperative day and then, 104 F, 105 F and terminally 107 F The blood pressure was 140/90 and the Wassermann test negative. The electrocardiogram on February 23 revealed auricular fibril lation with a ventricular rate of 95 and QRS of 0 08 A chest plate on February 16 revealed an enlarged heart with mitral pathology, and on March 13, pulmonary congection. A blood culture taken on March 3 was negative The blood count on February 24 revealed hemoglobin of 84 per cent red blood count of 40 million white blood count of 21 800 polymorphonuclears 80 per cent lymphocytes 18 per cent and monocytes 2 per cent on March 4, the white blood count was 25 600 with 89 per cent polymorphonuclears 9 per cent lymphocytes and 2 per cent monocytes. Sedimentation rate on February 17 was 2 mm. in five minutes and

on March 6 was 7 mm. in five minutes

Specific gravity of the urine was 1 019 to 1 033 with two plus abumin on three occasions and fine and coarse granular casts. The interus index on February 21 was 11 with van den Bergh direct. negative. Blood glucose on February 17 was 150 mg and urea nitrogen was 17 mg. per 100 cc Bleeding time was from three minutes on February 22 to twenty two minutes on February 25

Therapy was with theelin digitalis papaverine

heparin, and sulfadazine

The clinical diagnoses were rheumatic heart decase enlarged heart, mitral stenesis and insufficency auricular fibrillation, rider's embolus at the aortic bifurcation with gangrene of lower right ex tremity pulmonary infarct of lower right lobe.

The significant postmortem findings were as follows (autopsy by Drs Rudolph and Sherman)

The surface of both lungs revealed many purplish discolored areas which on cut section were square or rectangular in shape, oozed blood on compression, and were sharply demarcated from the surrounding The blood vessels leading to these areas revealed small emboli firmly adherent to the vessel One large infarct, measuring 4 inches by 4 inches by 3 inches, was noted at the right base posteriorly and its supplying artery was plugged by an embolus

The heart weighed 425 Gm No auricular thrombi-ere present The right ventricular wall measured 0.75 cm and the left ventricular wall, 1.5 cm the aper of the left ventricle were three thrombi protruding into the ventricular cavity No thrombi

were noted in the right ventricular cavity

The coronary arteries were normal. The tricuspid leaflets were thickened with fusion of chordae The mitral orifice was greatly narrowed tendineae The mitral valve leaflets were greatly thickened, stiff, and almost rigid. No vegetations were pres-The chordae tendineae were fused and The aortic cusps were thickened and semirigid with some widening of the commissures, but no fresh vegetations were noted

The liver weighed 1,600 Gm The capsule was smooth and glistening, the cut surface was finely

granular with moderate nutmegging

The spleen was small (250 Gm) There were
many pitted surface scars

The lower pole showed a gray-white discoloration which on cut section extended 2 cm into the parenchyma, this section was yellowish white and sharply demarcated from the surrounding beefy-red, trabeculated splenic tissue The left kidney weighed 85 Gm and in the upper

pole showed a deep old scar, fibrous on section, with a thin shell of cortex measuring 2 by 2 by 2 cm. The a thin shell of cortex measuring 2 by 2 by 2 cm right kidney showed six infarcts varying from 1 by 1 cm to 4 by 2 cm in size, they were grayish yellow

The aorta showed minimal atherosclerosis was a "saddle-embolus" extending from the lower portion of the aorta to both iliac and both femoral It extended up into the right renal artery arteries At the bifurcation, it was firmly adherent to the aortic wall

Microscopic study revealed thrombi filling the lumina of arteries leading to the various infarcted regions of the lung The liver showed chronic passive congestion and evidences of fine currhosis (increased intracapillary connective tissue) Some areas showed necross of liver cells due to hemorrhage

with compression atrophy of the cells

The anatomic diagnosis was rheumatic heart disease, mitral stenosis and insufficiency, aortic stenosis and insufficiency, tricuspid valvulitis, multiple thrombi, left ventricle, multiple infarcts of lungs, kidneys, and spleen, saddle-back thromboembolism of the aortic bifurcation, right renal artery thrombosis, chronic passive congestion of liver, and cardiac cirrhosis

Comment —In the present stress of psychosomatic medicine, the original impression by several capable observers was that the environmental background, the psychobiologic status of the patient, the distinct relationship of the symptoms to emotional stress and strain, and the paucity of objective findings warranted a diagnosis of anxiety neurosis subsequent course of events definitely proved that the symptomatology dating back three months had a definite organic basis

Case 2 -R W, a housewife, aged 51, was first admitted to the hospital on October 14, 1945, com planning of severe dyspines and a productive cough She had had scarlet fever at the age of 6 and typhoid fever at 8 She had been a known cardiac since the age of 21 with a history of frequent sore throats, parovysmal dyspnea, and ankle edema Tonsillectomy had been done at age 30 At the age of 27 she had gone through an uneventful pregnancy and labor, menopause was at 47 years

Admission examination revealed an acutely ill woman in pulmonary edema, double mitral murmur, RSR, the pulmonic second sound was greater than the aortic second sound, blood pressure was 140/82 There were signs of consolidation at the Chest x-ray revealed a heart enlarged in right base all diameters and a suggestive pulmonary infarct in the right lower lobe. On October 23, October 26, and October 30 she had episodes of chills with tem-perature rise to 102 F. Repeated blood cultures

were negative

On October 28 auricular fibrillation was noted for the first time and the patient was digitalized November 11 there was an episode of sudden pain down the left arm, followed by a sensation of numb-ness and coldness in that arm The left radial pulse was not palpable and no blood pressure reading was obtained in the left upper extremity. About a month later, the left radial pulse could again be palpated and the hand was of normal temperature The patient was discharged on December 18, 1945, with a final diagnosis of rheumatic heart disease, enlarged heart, mitral stenosis and insufficiency, auricular fibrillations, pulmonary infarction, and embolism to the upper left extremity

Laboratory data were as follows Electrocardiogram on October 19 showed regular sinus rhythm, with a rate of 80 On November 8 it showed suricular fibrillation with a ventricular rate of 75, there was an occasional pulsus bigeminus The Wasser mann test was negative Blood chemistry on Noglucose 115 mg, wea Maximum sedimentavember 15 was as follows nitrogen 28 mg per 100 cc

tion rate was 3 mm in five minutes

On admission hemoglobin was 88 per cent, red blood count 45 million, white blood count 11,200 On November 14 hemoglobin was 98 per cent, red blood count 48 million, white blood count 5,000, with 73 per cent polymorphonuclears, and 27 per cent lymphocytes Blood cultures on October 23 and 29, November 5, 8, 13, and 15 were negative Urinalyses were repeatedly negative

On February 9, 1946, the patient was re-admitted She had been on 0.2 mg of digitoxin daily and me-cupurin as indicated and had been well since her discharge until the afternoon of re-admission, when she experienced sudden pain in the left shoulder radiating down the arm and lasting a few minutes She then felt well until four hours later, when suddenly she felt pain in her right foot, which became white, cold, and numb After a short interval of treatment had a short interval of treatment by local heat at home, the lumb returned to its normal status Then there was a sudden stab of pain in the left lower extremity, which became cold, blue, and numb

Physical examination revealed moderate distention of the neck veins with the absence of normal systolic collapse. There were bilateral basal rales The cardiac apev was broad and heaving, palpable in the fifth left interspace beyond the midelavicular There was dullness at the lower end of the sternum with systolic heaving due to right ventricu-At the apex, a diastolic thrill was lar hypertrophy palpable, a snapping first sound and a middiastolic

The pulmonic second sound murmur were audible The rhy thm was totally irregular rate of 88 per minute. The liver was accontuated with a ventricular rate of 88 per minute. was palpable one finger's breadth below the costal margin. There was slight pretibial edema, bi laterally Examination of the extremities revealed the left toes to be colder than the right The right femoral, popliteal, and dorsalis pedis arteries were palpable. The corresponding vessels on the left wore not.

In view of our experience with Case 1 it was felt that the bilateral onset of signs indicated an in complete occlusion at the aortic bifurcation. The diagnosis was rheumatic heart disease enlarged heart mittal insufficiency and stonosis right and left ventricular hypertrophy auricular fibrillation Class IV E and saddle-back embolus to the ab-

dominal aorta bifurcation

The condition remained unchanged, but the right dorsalis pedis and popliteal arteries subsequently were not palpable and on March 4 1946, the right femoral artery also was not palpable No sensory changes were noted On March 6 oscillometric roadings were negative at all levels of both lower extremities. Skin temperature readings were diminished in both lower extremities more on the On April 10 oscillometric readings were negative throughout. Skin temperatures at this time revealed higher readings, especially toward the periphers. On May 2 oscillometric readings remained unchanged although subjective and objective im provement continued.

On May 8 the patient was discharged home with apparent recanalization on expectant therapy

aboratory data on this admission were as follows Liectrocardiogram on February 11 1946 showed auricular fibrillation with a vontricular rate of 80 and a QRS of 0 06 second and digitalis effect. nalyses showed red blood cells on February 15 naiyaes showed red blood cells on rebruary about were negative otherwise. Blood culture was negative on February 21. Blood count on admission was hemoglobin 104 per cent red blood count 51 million, white blood count 10 400 poly morphonuclears 74 per cent lymphocytes 24 per cent and monocutes? Per cent lymphocytes 24 per cent and monocutes of both cent, and monocytes 2 per cent. \ \-rays of both lower extremities on April 4 were negative for arterial calcification. Sedimentation rate on May 6 was 7 mm. in five minutes. The temperature was normal throughout.

Comment —The above case proves the wisdom of the dictum set forth by Reich! that we should anticipate the possibility of aertic bifurcation embelization in every case of rheumatic heart disease with auricular fibrillation, especially in women and more especially when emboli to other organs have oc-

curred.

In Case 2 the appearance of auricular fibrillation was followed shortly by embolization to the loft upper extremity and subsequently by 'rider's em bolism. In Case 1 the clinical background of mitral stences, chronic fibrillation, and clinical evidences of pulmonary infarction are also noteworthy

Case 1 exemplifies the recent explanation by Santemma' of the lower extremity pain being dependent not only on ischemia of distal peripheral nerves but more so on ischemia produced by lessened blood flow in the regional vessels, derived directly from the aorta, supplying the cauda equina and its component nerves. The blocking of the circulation in these regional vessels and not the conus medullaris circulation is said to produce the dermatome levels of impairment.

#### Discussion

Occlusive processes of the abdominal acrts bifurcation are due in 50 per cent of the cases to em bolism.\* Most frequently this occurs in women between the ages of 30 and 65 who have rheumatic heart disease, mitral stenosis, and auricular fibrillation. Other less frequent causes are cardiac infaretion with mural thrombus and embolization, and embolism from thrombi of luctic acrtitis.

Thrombo-arteriosclerosis of the aorta accounts for 35 per cent of similar occlusive processes. These instances of thrombotic phenomena superimposed on an aorta the site of ulcerative atheroma tous changes occur in 5 men to 1 woman and usually between the ages of 50 to 80

Less frequent predisposing etiologic factors are abdominal aorta aneurysm with mural thrombosis, infection (e.g., sepsis typhoid, tuberculous glands)

and retroperitoneal malignancy

One point bears emphasis. The recent knowledge concerning the thrombogenic effects of digitalis\*-1\* makes plausible the additional factor of digitalis administration bearing a role in promoting the forms tion of auricular thrombi which later embolise Then, too, the propagation of the embolus might be aided by the continuation of digitals medication. It remains to be determined whether or not the crystalline digitoxin preparations have similar thrombogenic properties. That they may have is indicated by Macht, 11 who also reports on the thromboplastic properties of mercurial diuretics. Hence the frequent exhibition of the mercurials may well be another factor in thrombogenesis. These conaiderations concerning thrombogenic properties of these medications need corroboration

#### Summary

We have presented two cases of 'rider's embolism to the bifurcation of the abdominal aorta. Both cases have been of the atypical onset described.

The frequent appearance of this syndrome in women with rheumatic heart disease mitral stenoas and auricular fibrillation has been stressed.

A new interpretation of the cause of the pain in the lower extremities and the anal and pelvic regions has been quoted.

The possible role played by the thrombogenic properties of digitalis and the xanthine derivatives and the thromboplastic properties of mercurial diuretics has been suggested

Early diagnosis to enable early treatment by the newer therapeutic methods has been emphasized.

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## MIXED EMPYEMA SECONDARY TO CHRONIC PARACHOLECYSTIC ABSCESS TREATED WITH STREPTOMYCIN

BERNARD J FICARRA, MD, and GEORGE H LORDI, MD, Brooklyn, New York

RECENTLY the management of a patient with mixed empyema revealed an underlying pathogenesis of unusual interest. It was only after the performance of an incomplete necropsy that the bizarre situation was unfolded. In view of these features the presentation of this case report is believed to be significantly valuable.

The patient was a 64-year-old housewife admitted to the Hospital of the Holy Family on August 18, 1946 She had been observed over a period of four years for gallbladder disease. During those years she was treated for diabetes mellitus as well as for chronic cholecystitis, the former condition being difficult to control in the presence of the latter. Two years before her hospital admission she had a serious exacerbation of gallbladder cohe associated with chills, fever, palpable right upper quadrant mass, and leukocytosis. After an illness of many weeks, her symptoms subsided. Cholecystogram at that time revealed cholelithiasis. An operation was

contemplated following this episode

Four months before her hospitalization she had another exacerbation associated with a septic course She recovered from this attack and progressed satisfactorily until four days prior to entering the hospital, when she again had a recurrence of her symptoms and, in addition, had nausea and vomiting. At no time did she have any jaundice. She was advised time did she have any jaundice. She was ad to enter the hospital at that time, but refused the day of admission the patient was almost in com-plete shock, having cold and clammy skin, blood pressure of 90/60, respirations 30, and pulse of 124 Chest examination revealed limitation of motion on the right side with absent breath sounds, and the usual signs of pleural effusion. The abdomen showed limited movement on the right side, marked tenderness, and right upper rectus rigidity liver was displaced 8 cm below the costal margin and Hospitalization was advised again and the patient finally consented to enter the hospital on August 18, 1946

Laboratory Data on Admission.—urinalysis 4 plus sugar, 3 plus acetone, blood sugar 320 mg, red blood count 4,040,000, hemoglobin 79 per cent, white blood count 15,000 with 82 per cent polymorphonuclears, total protein 65 Gm, blood type IV, and Rh negative Subsequent laboratory studies revealed negative blood cultures

The patient was treated conservatively, which included penicilin, by one of us (G L) who managed her diabetic state in preparation for future surgery An x-ray of the chest confirmed the presence of a large amount of fluid in the right pleural cavity. The left ventricle was enlarged and the aorta showed

slight widening

A thoracentesis was performed and 900 cc of fecal, foul-smelling pus were aspirated. The only improvement noted following this procedure was a fall in temperature from 103 F to 99 8 F. This improvement was temporary. Although her general condition was poor, it was decided to perform a thoracotomy. Culture showed the following organisms. Bacillus coli predominating with secondary

invaders, namely, Streptococcushemolyticus, Staphylococcus aureus, and Vincent's organisms

On the tenth hospital day a thoracotomy was performed, and 4,000 cc of pus were aspirated. A tube drain was inserted for twenty-four hours and the wound was then left wide open for drainage, aspiration, and treatment. One gram of streptomycin was placed into the pleural cavity. The patient's physical condition was very poor during the immediate postoperative period. One-quarter gram of streptomycin was given intramuscularly every four hours, and in addition, I Gm was instilled into the pleural cavity daily. Following the operation the temperature rose to 104 F. The next day it was 99 2 F. thereafter it maintained a low grade septic course (Fig. 1).

An x-ray of the chest following operation demonstrates.

An x-ray of the chest following operation demonstrated a diminution in the amount of fluid, however, the lower half of the lung field continued to be

obscured

Following the operative procedure the patient improved clinically. The diabetes was controlled, the liver was no longer palpable, respirations were not labored, and oxygen could be discontinued. Drainage from the chest was profuse and continued to be foul

On the seventh postoperative day the patient suddenly became worse. Her breathing was labored in spite of ovygen, and restlessness was constant. Her progress was decidedly downhill from that day forward. The pulse became rapid, the chest refilled with fluid, respirations became labored, and death finally supervened on the tenth postoperative day.

A limited postmortem examination identified the underlying pathology. The initiating lesion was chronic empyema of the gallbladder with cholehthiasis. A right paracholecystic abscess contiguous with the gallbladder and the undersurface of the liver was noted. A secondary abscess of 5 cm by 5 cm was present in the upper anterosuperior area of the liver. This latter abscess had perforated into the right subphrenic abscess had perforated into the right subphrenic abscess had eroded and perforated through the diaphragm, and thus entered the pleural cavity, resulting in the right-sided empyema, which evidently was the cause of the rapid filling of the pleural space (Fig. 2)

### Discussion

This case presentation illustrates an infrequently encountered complication of chronic gallbladder disease The clinical picture is one of exacerbations and recrudescences in a patient with diabetes mel-Her first episode of four years ago apparently was acute cholecystitis with a severe pericholecystic inflammatory reaction Two years later the septic course was interpreted by her family physician as empyema of the gallbladder with the possibility of a hepatic abscess Hospitalization and surgical intervention were refused by the patient at that time The septic course four months before entering the hospital was compatible with the formation of the hepatic abscess burrowing into the right, subdia-

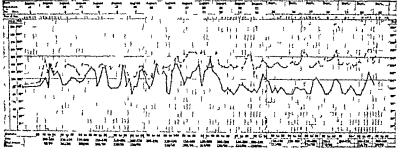


Fig 1 Temperature Chart.

phragmatic space The period preceding hospitalization was the time in which the subphrenic abscess was ereding into the pleural space. When the pleural cavity was finally entered the patient presented the picture of shock.

It appeared as if every episode of serious gall bladder colic stimulated inflammatory activity and accolerated abscess formation. This was a chronic process extending over a four-year period. The abscess formations plus the diabetes were the even tual cause of death occurring in spite of the administration of penicillin and streptomyem.

The culture taken from the pleural cavity identified a variety of organisms which produced the mixed type of empyema. Because of the variety of organisms both penicillin and streptomycin specific for B coll were employed. In spite of this intensive therapy and surgical drainage the patient succumbed.

### Summary and Conclusions

1 An unusual case is presented of putrid, mixed empyema secondary to chronic purulent infection of the gallbladder and caused by B coli.

2 At the end of a four year period the patient developed a paracholecystic abscess, a hepatic abscess, and a subphrenic abscess which eroded into the pleural cavity

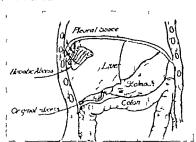


Fig. 2. Anterior view of the abdomon showing original paracholocystic abscess and the metastatic hepatic abscess with its passage into the subphrenic space and finally its entrance into the pleural cavity through the disphragm.

3 Treatment consisted in controlling the dia betes, open thorseotomy and the administration of streptomycin both in the pleural cavity and intra muscularly plus pencillin.

4 Death supervened in spite of intensive medical treatment and surgical intervention

567 First Street

### FREQUENCY BANDS FOR MEDICAL DIATHERMY EQUIPMENT

Medical diathermy equipment may be operated on the 13 66-megacycle, 27.32 megacycle, and 40 98-megacycle bands without license according to Public Notice #7723 of May 9 1947 released by the Federal Communections Commission No limit is given to the power output that may be radiated Diatherny appearatus operated outside the assigned frequency bands above shall be completely shelded and filters placed in the power line. The Commission will determine if the diathermy equipment is not operating in compliance with the rules and in such cases will notify the owner who is responsible for making the changes to prevent interference.

All equipment manufactured before July 1 1947, will not be subject to the new regulation for a period of 5 years (June 15 1952)

A special band at 2,450 megacycles has been made available for industrial, scientific, and medical purposes. This is to allow the production of experimental machines of extremely short wavelength—approximately 12 contimeters long. Such machines have not been used by the medical profession up to the present time. However this channel may be subject to development in later years as the medical profession either accepts it or not.—Secretary s Letter A M.A. June 30 1947

### MEDICAL NEWS

### Public Health Grants for Cancer Research

PUBLIC health grants of \$363,749 have been awarded recently by the Federal Security Agency to universities and state health services for cancer

research and control

The grants, part of the \$14,000,000 program authorized by Congress for the 1948 fiscal year, will finance research on improved technics for professional cancer instruction, a nation-wide survey of cancer clinics, and evaluation of various cancer control measures

The projects were recommended by Dr A V

Deibert, chief of the national cancer institute's cancer-control subdivision, and were approved by the National Advisory Cancer Council, a non-governmental committee of cancer specialists. They included The American College of Surgeons, \$30,-340, to survey cancer clinics throughout the United States, American Cancer Society, \$36,600, for a cooperative project for production of diagnostic motion pictures, Yale University Medical College, \$2,000, improvement of cancer teaching, Cornell University, \$37,800, a cytologic diagnosis center

### Academy to Have Lectures to the Lasty

THE New York Academy of Medicine, 2 East 103rd Street, New York City, is now sponsoring

103rd Street, New York City, is now sponsoring its thirteenth series of lectures to the laity. The subject of the series is "Perspectives in Medicine". Dr. George Ronald Hargreaves, former assistant director of the Army Psychiatric Division, British War Office, will speak on "The Psychology of Leadership in War and Peace," on Wednesday evening, November 19, at 8 30 PM. Presiding chairman at the lecture will be Dr. Frank Fremont-Smith "Food and Civilization" will be the subject of Sir Raphael Cilento director of the Division of of Sir Raphael Cilento, director of the Division of Social Activities for the United Nations, Lake Success, who will speak on Wednesday night, December 17, at 8 30 PM Dr Frank G Boudreau will be chairman

Dr Edward J Stieglitz, chief of medical staff, Suburban Hospital, Washington, D C, will have as

his subject, "On Being Old Too Young," on Thursday night, January 22 Chairman for the lecture will be Dr Russell L Cecil Dr Cornelius P will be Dr Russell L Cecil Dr Cornelius P Rhoads, director of Memorial Hospital, New York City, will speak on "Perspectives in Cancer Research," on Wednesday night, February 4 Presiding chairman will be Dr Harold Brown Keyes. Dr William C Menninger, of the Menninger Foundation, Topeka, Kansas, will give the George R Siedenburg Memorial Lecture on Thursday evening, February 26 His subject will be "Psy chiatry for Everyday Needs" Dr Thomas A. C Rennie will be presiding chairman On Thursday evening, March 11, Dr James B Conant, president of Harvard University, will speak on "The Interelation of Pure and Applied Science in the Field of Medicine" Presiding chairman for the lecture will be John W Davis be John W Davis

### Neuropsychiatric Residencies Available in New Jersey

OPENINGS are available in neuropsychiatric residency at the Veterans Administration Hospital, Lyons, New Jersey The residency has been approved by the Council on Medical Education and Hospitals, the American Medical Association, and by the American Board of Psychiatry and Neu-

rology
The course consists of one, two, or three years' training with intensive postgraduate teaching in clinical neurology and psychiatry, psychopathology,

clinical psychology and related sciences, neuro anatomy, neurophysiology, neuropathology, and neuroroentgenology

The type of instruction, supervision, and train ing is carried out in accordance with the requirements of the American Board of Psychiatry and Neurology

For further information, apply to Dr A Pauncz,

acting director of professional education, Veterans Administration Hospital, Lyons, New Jersey

### Education for Prevention Chief Goal of Venereal Disease Fund Drive

E ARLY detection and treatment of venereal diseases to minimize the spread of infection from person to person will be the primary aim of the 1948 program of the American Social Hygnene Association, Howard S Cullman, chairman of the Association's current New York fund-raising campaign, said recently

The major factor toward the disease's control must be to bring the victim to the doctor before the germ is passed on The Association plans to work closely with government health agencies, hospitals, and other groups in intensifying its educational program for early treatment, while continuing its general education for prevention

#### PERSONALITIES

Retired.—Dr Aendall Emerson managing director of the National Tuberculosis Association, after twenty years work with the organization managing director since 1928, effective January 1, 1948 Dr Douglas Gordon, head of Odell Sanatorium, Newburgh, since 1947 Dr Edward McPherson Armstrong medical director of the Mutual List Insurance Company of New York for the past

twenty-eight years

Honored.—Dr James C McClelland Toronto, recently elected president of the Western New York and Ontarno Urological Society Dr J Sydney Ritter New York City, who discussed Renal Neoplasms" at the Third American and Fourth Brailian Urological Congress in Ruo de Janeiro recently at the invitation of the Brazilian government. Dr Donald P Ross Niagara Falls, former commander in the U.S Naval Medical Corpe navarded a commendation ribbon for 'excellent service in line of his profession on Iwo Jims in March, 1945 Dr A. M Crance Geneva re-cleoted secretary and treasurer of the Western New York and Ontario Urological Society. Dr Walter S McClellan, medical director of the Saratoga Spa, who presided at the twenty fifth annual meeting of the American Congress of Physical Medical in Minneapolis, Minnesota, in September Dr Mary Theress Green, who has recently completed her fiftieth year of medical work at the Wyoming County Sanitarium where she has been proprietor and medical director

Appointed.—Dr James E. Perkins, former deputy commissioner of the Stato Health Department, who served with the Italian Medical Nutrition Mission as codirector of the epidemiologic branch, effective January I, managing director of the National Tuber culosis Association. Dr Milton J Matsmer, Brooklyn, who served as commander in Naval Medical Corps during World War II, as consultant in gnatureenterology to the Veterans Hospital at Manhattan Beach Dr Wendell R. Ames, former health commissioner of Cattaraugus County, as director of the medical care section of the Baltumore,

Maryland, Department of Health Dr Jesse D Stark New York City, choof roentgenologist of Gouverneur Hospital, as surgical consultant in radiology for the Station Hospital, United States Military Academy West Point Dr Granville W Larimore, New York City, educational director of the American Cancer Society for the past year and chief of the Army's Health Education Unit during World War II, as director of the State Department of Health & Odice of Public Health Education

New Officea.—Dr John F Flynn, Addison after five years sorvice in Naval Medical Corps, now associated with Dr Luther A. Thomas at the Thomas Clinic in Painted Post. Dr James P Hoffman, in Bolivar, for practice of general medicine. Dr Leonard M Niesen and Dr Joseph P Gold, formerly of the Van Winkle Clinic new offices

in Hudson

Dr Ralph M Cudlipp Jr Winthrop, where he is associated with his father, also now practicing medicine in North Lawrence and Hopkinton Dr Lowis J Graham, Corning formerly with the Navy Medical Corps attached to the Marine Corps, and for the past two years medical director of the Corning Glaza Works, now associated with Dr L. E. Whipple in Corning Dr Philip Hust, physician in Hamden for the past seven years, now in Delbi.

Dr George F Nevin Newark, battalion surgeon with the 85th Regiment of the Tenth Mountain Division in the Italian Campaign during World War II associated with Dr Hugh Frail in Marathon Dr Paul W Myers Schoharie with Dr Donald C Walker for the practice of general medicine in Delanson. Dr Tobias M Rubin, in Yonkers for the practice of general medicine and surgery after being chief of medical service of the U.S. Armys 85lst Station Hospital in Tokyo. Dr L. D. O Nelli, after three years of active duty with the U.S. Seventh Fleet amphibious and submarine service, former physician in charge of medical and surgical service at Central Islip Hospital Central Islip now in general practice Valloy Stream.

### COUNTY NEWS

#### Albany County

"Recognition and Treatment of Electrolyto Disturbances in Diarrhea was the topic of Dr Daniel Cady Darrow professor of pediatrics at Yale University Medical School, when he spoke to mem bers of the Albany County Medical Society at their meeting on October 22 at the Albany College of Pharmacy

Following his talk, a lengthy discussion was held, with Dr Otto Faust and Dr Hugh Leahy as

leadera.

### Allegany County

At the September meeting of the Board of Super visors of Allegany County a lotter from the Medical Society of the County of Allegany was read, requesting the board to "reconsider the cetablishment of a county health unit and subsequent county hospital plan in Allegany County."

of a county health unit and subsequent county hospital plan in Allegany County. The Woman's Auxiliary of the Allegany County Modical Society also advised the Board that it had passed a resolution asking that the county health service plan be resubmitted to the Board and went on record as unanimously in favor of that plan, ask ing that action be taken at the earliest possible date

#### Bronx County

'The Sanitary Code as Related to Obstetres in the Hospitals' was the subject of a talk presented to members of the County Society on October 15 by Dr Samuel Frant, doptuy commissioner of health. The discussion was opened by Dr W John Dolan Dr Samuel Weiskopf newly elected president of the Society gave his inaugural address at the meeting

#### Broome County

Dr Hyman Spelcrson was the speaker at the scientific session of the October meeting of the Broome County Medical Society His subject was Surgery in the Patient Over Sixty five

#### Cayuga County

With the cooperation of the Cayuga County, Medical Society and the County Dopartment of Health, arrangements were made to provide free x ray examinations for all Cayuga County residents over fifteen who had not had such an x ray taken within the past three years. The program was supervised by the Cayuga County Health Association and expenses were met from funds derived from the sale of Christmas seals.

### Chemung County

Dr David J Kaliski, director of the Bureau of Workmen's Compensation of the Medical Society of the State of New York, acted as moderator of a panel discussion on workmen's compensation, held on September 17 in Elmira at the meeting of the Chemung County Medical Society Among the members of the panel were Dr Norman's Moore, of the State Society, and Dr Laurence Hobler, of the County Society

At the business meeting which followed the discussion, the resignation of Dr E F Butler as chairman of the Compensation Committee was accepted, and Dr W J Gusick was appointed chairman Dr Butler has been appointed second in charge of the Veterans Administration in New York State Also named to the committee was Dr J H Burke, Jr

A business meeting of the County Society was held on October 8 at the Arnot-Ogden Hospital, in Elmira, with the main topic of discussion being the report of the Public Health Committee on the adoption of a County Health Unit Dr George Murphy reported that the Health Unit had failed to be approved because of a lack of support by the members and their failure to contact their supervisors to request favorable action. The matter had been tabled by the Board of Supervisors, and it was stated to be too late to revive it this year Dr W R Phillips moved that the County Society go on record as standing behind the Health Committee's report of last year in favor of the establishment of a County Health Unit, and that the County Supervisors should be so notified. The motion was seconded and unanimously approved.

Dr George Murphy reported on the meeting of October 1 with representatives from the Council of Rochester Regional Hospitals, and explained the advantages of joining in this eleven county test plan. The members unanimously approved joining the

Dr J Scott Howland, reporting for Dr Lynch on the Cancer Committee meeting, stated that the Community Chest had allocated \$10,000 for cancer work, \$6,000 of which is to be spent locally. The following two recommendations were made by the Committee (1) the possible setting-up of two cancer detection clinics in the city, one at each hospital, (2) the acceptance of the State's offer of free radium for treatment of cancer patients in this area. At Dr Howland's recommendation, the Society accepted the State's offer of radium. The motion that the formation of two cancer detection clinics in the city be approved resulted in a tie, and the president then appointed a committee to work out the details of a cancer control program and submit it at the next meeting. Members of the Committee are Drs. J. F. Lynch, R. Scott Howland, A. H. Hillman, W. T. Boland, H. L. Walker, F. S. Hassett, H. Burch, and S. E. Cohen.

### Clinton County

"The Management of Diabetes with the Various Forms of Insulin" was the subject of a lecture given to the County Medical Society by Dr Byron D Bowen on October 16 Dr Bowen is professor of clinical medicine, University of Buffalo, School of Medicine The lecture was a cooperative endeavor of the Council Committee on Public Health and Education of the State Medical Society and the New York State Department of Health

### **Dutchess County**

Dr Gerald Pratt, of New York City, spoke to members of the Society on October 8 at the monthly meeting His subject was peripheral vascular diseases

Postgraduate instruction, arranged for the County Society by the State Medical Society in cooperation with the State Department of Health, was given on November 12 by Dr Frederick S Wetherell, professor of clinical surgery, Syracuse University, College of Medicine His lecture was entitled "The Relation of the Sympathetic Nervous System to General Medical Problems"

### Erie County

The 1947-1948 season of the Medical Society of the County of Erie began on October 28 with a program titled "Chinical Afternoon and Evening" at which three outstanding physicians in their respective fields were heard. At the afternoon session Dr. Frank. H. Lahey, of Boston, discussed "Present Concepts in the Surgical Treatment of Peptic Ulcer, Resection v. Vagotomy," and Dr. Sidney Farber spoke on "The Treatment of Cancer in Children" Dr. Farber is chairman of the Division of Laboratories and Research of the Children's Hospital, Boston, pathologist-in-chief of the Children's Hospital, and assistant professor of pathology at Harvard Medical School

Also speaking at the afternoon session was Dr Louis M. Hellman, associate professor of obstetrics, Johns Hopkins Hospital, Baltimore His subject was "The Use of Pituitrin in Obstetrics."

At the evening session Dr Lahey again addressed the group with a talk entitled "Management of Diseases of the Thyroid Gland"

### Jefferson County

Two programs of postgraduate instruction, arranged by the Council Committee on Public Health and Education of the Medical Society of the State of New York, were held recently for members of the Jefferson County Medical Society, at the Woodruff Hotel, Watertown
On October 9, Dr Robert O Gregg, associate

On October 9, Dr Robert O Gregg, associate professor of clinical surgery at the Syracuse University, College of Medicine, spoke on "Treatment of Massive Hemorrhage from Peptic Ulcer," and on November 13, Dr Joe W Howland, instructor in medicine at the University of Rochester, School of Medicine and Dentistry, spoke on "Medical Aspects of the Atomic Bomb"

### Kings County

Three lectures were presented to the County Society members at the scientific program of the October state meeting "Differential Spinal Block" was the subject discussed by Dr Stanley J Sarnoff, research and clinical fellow, department of surgery, Harvard Medical School, and "Sulfadiazine and Penicillin Prophylaxis in Prolonged Labor with Special Reference to Cesarcan Section" was the subject of Dr R Gordon Douglas, associate professor of obstetrics and gynecology, Cornell University Medical College, and obstetrician and gynecologist, New York Hospital The last lecture, entitled "The Cancer Problem in Brooklyn," was presented by Dr S Potter Bartley, chairman of the Brooklyn Cancer Committee of the American Cancer Society, Inc

The final Friday afternoon lecture of the fall season will be given on November 21 on the subject of abdominal surgery in infants and children. The lecturer will be Dr. William H. Lanman visiting surgeon, Children's Hospital, Boston, and assistant professor of surgery Harvard Medical School

The medical profession is cordially invited to attend a meeting of the Pediatric Section of the Kings County Medical Society on Monday ovening, November 24 at 9 00 r m at the Medical Society of Budding, 1313 Bedford Avanue Brooklyn Dr William Damesbek, of Boston, will speak on Blood Diseases in Inlancy and Childhood and Their Treatment.

#### Livingston County

Members of the Lavingston County Medical Society met on October 1 as the guests of the medical staff of Craig Colony Sonyea. Dr Douglas Taylor of Toronto, presented an illustrated talk on "Ar thritis, Its Diagnosis and Treatment."

#### New York County

Philip McCord Morse Ph.D., was the principal speaker at the October stated meeting of the New York County Medical Society Dr Morse, director of the Brookhaven National Laboratory explained the important developments of radioactivity its scope and the effect of atomic radiation on health, nutrition disease, and pathology Dr Lloyd F Craver, of the Memorial Hospital discussed the talk, telling of the pioneer work in the application of atomic radiation in the field of cancer research

#### Oneida County

Dr Charles LoRoy Steinberg, senior visiting physician and physician-in-charge of the arthritis clinic at the Rochester General Rospital spoke on chronic arthritis at the meeting of the Oneida County Medical Society on October 14 at the Rome State School, Rome.

The lecture was part of the postgraduate instruction arranged by the Council Committee on Public Health and Education of the Medical Society of the State of New York, for the County

#### Society

#### Onondaga County

A symposium entitled 'The Appraisal of Rational General Practice was held at the October meeting of the County Medical Society Participants in the discussion were Dr W Walter Street and Dr Paul C Clark. Dr Richard II Lyons was moderator

#### Queens County

The annual joint meeting of the Queens County Medical Society and the Queensboro Tuberculesis and Health Association was held on September 30 The program included a talk by Dr. Carl Muschen leim, assistant professor of clinical medicine at Cornell University Medical Collego, on 'Streptomycin in the Truatment of Tuberculesis, and a talk by Dr. Milton I Levine, assistant professor of pediatrics at Cornell University Medical College, on 'The Present Status of BCG'

#### Schoharie County

Three programs of postgraduate instruction arranged by the Council Committee on Public Health and Education of the Medical Society of the State of New York for the Schoharze County Medical Society were held during October The first two at the Cobleskill Library Cobleskill, were

given by Dr David P Earle Jr., assistant professor of medicine at the New York University College of Medicine, on "Renal and Cardiae Aspects of Arteriosclerosis and Aging, and by Dr A. Wilbur Duryce, associate clinical professor of medicine, College of Physicians and Surgeons, New York on Peripheral Vascular Aspects of Arteriosclerosis and Aging

At the annual meeting on October 14 at the Coblekill Golf Club a talk on "Neuropsychatrac Aspects of Arteriosclerosis and Aging" was given by Dr Morris Herman associate professor of psychiatry at the New York University College of Medicine

#### Suffolk County

Dr Albert F R. Andresen, professor of clinical medicine Long Island College of Medicine, presented a postgraduate lecture to members of the County Society on November 5 His instruction on gallbladder disease was provided by the State Medical Society in cooperation with the State Department of Health

### Sullivan County

Dr Eldridge H. Campbell professor of surgers and director of the department at the Albany Medical College spoke on "Brain Tumors" at the meeting of the Sullivan County Medical Society held on October 8 at the Lenape Hotel Liberty The program of postgraduate instruction was arranged by the Council Committee on Public Health and Education of the Medical Society of the State of New York for the County Society

#### Ulster County

The Rh factor was the subject of the scientific session of the fall meeting of the Ulster County Medical Society held October 7 at the Kingston City Laboratory. The speaker was Dr Irving B Wexler of the Brooklyn Jewish Hospital who was a coworker in the original research work on the Rh factor Participants in the discussion which followed were Drs. John B Krom, F. E. O Connor E. S. Goodyear, J. J. Jacobson and J. S. Taylor Dr Alfred M. Feldshuh was chairman of the meeting.

#### Warren County

Postgraduate instruction arranged by the Council Medical Society of the State of New York for the Warren County Medical Society was the feature of the annual meeting held October 9 at Glens Falls Dr Thomas H McGavack, professor of clinical medicine at the New York Medical College spoke on The Treatment of Hyporthyroldism.

#### Wayne County

Dr John C. M Brust, associate professor of surgery at the Syracuse University College of Medicine spoke on The Bignificance and Management of Infections of the Anua, Rectum, and Coceyx, at the meeting of the Wayne County Medical Society on October 14 at Lyona. The program of postgraduate instruction was arranged for the County Society by the Council Committee on Public Health and Education of the Medical Society of the State of New York.

#### Westchester County

Dr Froderick W Williams president of the New York Diabetes Association, spoke to members of the County Society at the monthly meeting in October His talk was ontitled 'Present Status of the Treat ment of Diabetes—Including Surgical Complications of the Lower Extremities.'

### HOSPITAL NEWS

### Seven Hospitals Join New York University Study Plan

THE Regional Hospital Plan of the New York University College of Medicine is now in progress with twenty-four doctors from seven hospitals within a 100-mile radius of New York participating

The new program, according to Dr Clarence E de la Chapelle, associate dean and director of the college's postgraduate division, is designed "to bring to independent, nonteaching hospitals, the advantages of a working relationship with a university medical school" It will make possible, he explained a continuing process of education to staff members of affiliated hospitals

Dr de la Chapelle said that emphasis would be placed on the training of interns and residents, with particular attention to the training of residents in the basic sciences as applied to the various fields of

medicine and surgery

Spending a full academic year at the College of

Medicine, residents of affiliated hospitals will study subjects applicable to their residencies and will receive intensive instruction in the basic medical sciences

The hospitals participating in the plan will be required to supply maintenance facilities for the student-doctors. The university, however, will not charge tuntion fees. Doctors enrolled in the program have agreed to return to the member hospitals for at least a year following the course.

program have agreed to return to the member hespitals for at least a year following the course Organizations that have enrolled in the program are Grasslands Hospital, Valhalla, New Rochelle Hospital, Flushing Hospital and Dispensary, Monmouth Memorial Hospital, Long Branch, New Jersey, Fitkin Memorial Hospital, Neptune, New Jersey, North Country Community Hospital, Glen Cove, Long Island, and St Luke's Hospital, Newburgh

### Hospitals to Cooperate in Food Emergency Campaign

GRAHAM L Davis, president of the American Hospital Association, has called on the nation's hospitals to cooperate with President Truman's request to observe meatless Tuesdays and to serve no poultry or eggs on Thursdays as their contribution to the Food Emergency Campaign "Compliance with the President's request," Mr

"Compliance with the President's request," Mr Davis said, "should be possible in so far as meals to hospital personnel and routine food service to patients must necessarily follow the physicians' recommendations in the interest of proper patient care"

An average of 1,142,000 patients are in the nation's

6,125 hospitals of all types, Mr Davis pointed out, and he said the hospitals can make substantial contributions to the program "Hospitals purchase an average of six ounces of meat per patient per day. Thus, a possible daily saving of meat in hospitals among patients alone amounts to approximately 6,852,000 ounces or 428,250 pounds for each Tuesday the meatless campaign is observed. In addition, he stated, "these hospitals employ approximately 830,000 full-time personnel, many of whom eat one or more meals daily in hospitals, a source of a considerable additional saving"

### **NEWS NOTES**

The site of the new Edward John Noble Hospital in Gouverneur will be on the south side of West Barney Street, according to a recent announcement by hospital authorities, and will be high above the north bank of the Oswegatchie River The hospital is scheduled to have 60 beds. It is one of the three hospitals planned for the North Country section of the State, the other two being at Alexandria Bay and Canton

A plan for establishing a central purchasing program for the twenty member hospitals of the Council of Rochester Regional Hospitals was approved recently by the Council's board of directors, giving to the hospitals a joint membership in the Hospital Bureau of Standards and Supplies Membership will enable the Council to make quantity purchases at a saving of hospital costs The Council includes hospitals in Wayne, Yates, Ontario, Seneca, Monroc, Orleans, Chemung, Allegany, Schuyler, Steuben, and Livingston counties

Last year 10,424 patients received 108,066 days of care, the majority of them without fee or below cost, in Beth Israel Hospital, New York City, according to the hospital's fifty-seventh annual report. The largest nonsectarian hospital conducted under Jewish auspices, Beth Israel had 178 postgraduate physician-students enrolled for four to sixteen weeks for specialization during the 1946 to 1947 academic session. The hospital was founded in 1890 "to establish and maintain a hospital in the City of New York where poor people will receive medical advice and treatment free of charge"

Three cancer-prevention clinics, established by the Brooklyn Cancer Committee during the last year, reopened this fall after a summer recess, it was announced by Dr S Potter Bartley, committee chairman The clinics are at the Brooklyn Cancer Institute, Methodist Hospital, and St Mary's Hospital Appointments for examination at these clinics may be made at the Little Red Door Information Center

Members of the netive medical staff of Little Falls lospital were hosts in September to the hospital sensulting staff of specialists Dr Joseph Conrad is president of the staff and Dr A L Lombardi was chairman of the program committee. Consultants attending were Dr Ross D Helmer of Jordanville, formerly of Utica Drs L. L Bryan, P L. Turner M Stovens, R. C Hall Edward Evans, and H D Parkhurst, all of Utica and Dr Herbert Schwarts superintendent of Pine Crest. Also present were Dr Evelyn Rogers, of Utica district State health officer and Dr David Park, a representative of the American College of Physicians and Surgeons.

Oswego Hospital was observed in action by the citizens of Oswego during the hospital s open house in September Demonstrations, with medical staff menand technicans in attendance were set up in the emergency room, v rav department operating room maternity department, and laboratory Physicians who participated were Drs. Grover C Elder Francis L. Carroll, L. Wood Jarvis Bonjamin Seldenberg Ohn J Mowry, Harvey S Albertson Milton W Kogan Frank Frost Gaspar J Fatta, and G A Marsden

A special pain clinic to instruct medical special ists and educators throughout the United States in the nerve block technic of anesthetics has been opened at New York University College of Medicine. The first of its kind, the newly formed clinic will put into practice the revised procedures of nerve block technic that have been developed since the war Dr F A. Rovenstine is chaliman of the department of anesthesia at the College

Appointed.—Dr David II Ross, connected with the Mount Sinal Hospital in New York City since 1941 as the director of the Jewish Hospital Cincin nati Ohio Dr Loo W Tuckor, executive officer of the U.S. Marine Hospital on Staten Island since July, 1945 and veteran of twenty-six years' service in the U.S. Public Health Service, as chief quarantine officer for the Hawalian Islands and officer in charge of the medical reliof station in Honolulu. As associate professor in the department of medicine of the Yake University School of Medicine Dr David M Kydd, former associate in medicine at the Mary Inugene Bassett Hospital in Cooperstown where he was an active member of the staff for thirteen years

Dr. Alexander Brunschwig, former professor of surgery at the University of Chicago as a department head at Memorial Hospital, Center for Cancer and Allied Diseases in New York, City and as professor of clinical surgery at Cornell University, Medi-

cal College.

Eloven staff members of hospitals in New York City and Cooperstown to the staff of the College of Physicians and Surgeons, Columbia University from St Lukes Hospital, New York City Dr William F Maelee as clinical professor of surgery Dr Bonjamin Shore and Dr Paul Calhoun Morton as assistant professors of surgery, Dr John J Keating, Dr Albort C Herring, and Dr Waldo B Farnum as assistant clinical professors of medicine from Goldwater Memoral Hospital Wolfaro Hand, Dr Margaret Bovans as assistant clinical professor of pathology Dr Robert W Berliner as assistant professor of medicine and Dr David Tanchester as clinical professor of dentistry, from the Mary Imogene Bassett Hospital in Cooperatown, Dr James Bordloy III as associate clinical professor of medicine, and Dr Monroe A McIver as associate professor of surgery

### NUTRITION MAY BE FACTOR IN POLIO

A study of the 1946 infantile paralysis outbreak in Chicago shows increasing incidence of the disease in higher age groups, especially in rural areas, and emphasizes the importance of nutrition in its background, two physicians reported in the September issue of the Illinois Medical Journal official publics then of the Illinois State Medical Society

The two physicians are Archibald L. Hoyne M.D., superintendent of the Chicago Municipal Contagious Disease Hospital and Peter J. Cotafrilos M.D. pediatnes divison Cook County Hospital.

Reviewing 225 cases of pollomyelitis admitted to the contagious disease department of Cook County Hospital in 1946 out of 1006 reported for Cook County during the year the two doctors emphasized nutrition as 'what has seemed to be a constant factor in susceptibility to the disease in years past and has become increasingly apparent.

In discussing the physical characteristics of pollo-

In discussing the physical characteristics of pollomyelitis patients in 1916 one of us described the victims as exceptionally well nouristed and mentoned the fact that the discase somed to prefer blondes. Some thirty years ago a negro with pollomyellitis was quite a rarity among our hespital patients.

More recently the Negro race has contributed a much greater number of cases during epidemic periods. Can it be that a higher scale of living with general improvement in nutrition and sanitation is responsible for this change?

They also recalled reports in medical literature indicating that a deficiency of thiamin one of the B vitamins seemed to necessor resistance to the disease in experiments with mice. Some authorities believe that the virus, as a parasite organism lacking the power to live independently, must have a well-pour ished heat on which to feed. Poorly nourished children therefore may exhibit a relatively greater re-

There were 51 negroes among the 225 patients more than 22 per cent of the total.

The authors pointed out also that in the last 30 years the number of adults stricken with infantile

sistance to the disease.

paralysis has been increasing.

A higher susceptibility was also noted in the case

studies for rural patients in the older age brackets.
Commenting on the symptoms axidiated by the
225 patients, the physicians noted that fever was the
most characteristic 218 of the patients running a
high temperature

Other common symptoms the onset of which usually occurred within four days, were stiffness of neck, 172 cases headacle 150 stiffness of back 130 loss of appette 101 vorming 95 and naives SE Fifty four patients complained of sore threat

and 46 listlessness.

### **NECROLOGY**

Howard Dennis Collins, M D, 79, of Millbrook, died on October 8 After graduating from Yale University in 1890 and from the College of Physicians and Surgeons, Columbia University, in 1893, Dr Collins practiced medicine in New York for twenty years He served in World War I as a major in the Army Medical Corps From 1895 to 1904 he was an assistant demonstrator of anatomy at the College of Physicians and Surgeons and was attending surgeon at Knickerbocker Hospital, New York City, from 1906 to 1919, and at City Hospital, Welfare Island, from 1907 to 1925 Dr Collins retired from active practice soon after the war, but remained with City Hospital as a consulting surgeon With W H Rockwell he wrote Handbook of Physiology, he also contributed to Johnson's Surgical Technique He was a member of the New York Surgical Society and the Academy of Medicine, a fellow of the American College of Surgeons, and a member of New York State and Dutchess County medical societies

Edwin Thomas Redmond, MD, of Brooklyn, died on October 8 at the age of 54 He was graduated from Eclectic Medical College in Cincinnati, Ohio, in 1916 Dr Redmond was pediatrician at the Prospect Heights and Brooklyn Nursery and Infants' hospitals, both in Brooklyn He was a member of the New York State and Kings County medical societies and of the American Medical Associ-

John Wilson Sayer, M D, of Watertown, died on September 25 at the age of 37 He was graduated from Syracuse University, College of Medicine, in 1935, and then completed postgraduate work at St Vincent's Hospital, Staten Island, and St Joseph's Hospital, Syracuse Dr Sayer practiced medicine in Gouverneur until he entered the US Army Medical Corps in December, 1940 For eighteen months he was on duty in the European Theater of Operations, specializing in anesthesia He completed a residency in anesthesiology at Flower Fifth Avenue Hospital, New York City, last year and had since been engaged in the practice of anesthesiology in Watertown He was also on the staff of the Van Duzee Hospital in Gouverneur Dr Sayer was a member of the American Society of Anesthesiology.

the Jefferson County and New York State medical societies, and the American Medical Association

Clarance Henry Smith, M D, 72, of the Bronx, died on October 6 After graduating from Bellevue Hospital Medical College in 1899, Dr Smith interned at the Smith Infirmary, now the Staten Island Hospital For ten years he had a general medical practice and then specialized in ear, nose, and throat medicine For twenty-five years he was a faculty member of the New York Post-Graduate Medical School, and since 1934 he was professor of clinical otolaryngology there He was consultant in ear and throat diseases at Mother Gabriel Memorial, Morrisania, Bronx, Union, and St Elizabeth's hospitals, all in the Bronx He was also an ear special ist at the Manhattan Eye, Ear, and Throat Hospital, and a consultant at the Bronx Eye and Ear Infirm ary

Dr Smith was a diplomate of the American Board of Otolaryngology and a fellow of the American College of Surgeons and the Academy of Medicme. He was a member of the Bronx County Medical Society, the American Medical Association, the American Laryngological, Rhinological, and Otological Society, the American Academy of Ophthalmology and Otolaryngology, and the American Otology Society

Frederic E Sondern, M D, 80, of New York City, died on October 10 A pathologist credited with introducing several testing technics to the United States, Dr Sondern was a former president of the Medical Society of the State of New York He was graduated in 1889 from the College of Physicians and Surgeons of Columbia University and served his internship at German Hospital, now the Lenor Hill Hospital

He was associated with Post-Graduate Hospital, New York City, and at one time was president of its medical school Dr Sondern was also a past-president of the Society of Clinical Path ologists, and a member of the American Society of Pathologists and Bacteriologists, the Academy of Medicine, the New York Pathological Society, and the American Medical Association

A memorial to Dr Sondern appears in this issue of the Journal on page 2413

### 1948 MEETING OF THE AMA TO BE IN CHICAGO

The House of Delegates of the American Medical Association selected Chicago as the 1948 convention city, Atlantic City for the session in 1949, and San Francisco in 1950

Important among the resolutions adopted recently by the house of Delegates was the one discharging the Committee on National Emergency Medical Service and constituting this body as a council of the Board of Trustees, to be known as the Council on National Emergency Medical Service This is a real progressive step, and the work of this group will go forward toward planning for medical care of civilians and military personnel in the event of a national emergency

Adopted in toto were the recommendations made by Dr Edward L Bortz of Philadelphia, our new president They were

1 A two-day scientific session for general practitioners at the time of the semiannual meeting of the House of Delegates.

2 Change of meeting place for the semiannual session—to convene in a different geographic district each year—at which time the two-day session for general practitioners would be held

3 Closer affiliation with third and fourth year medical students—possibly by affiliate membership—and re-establishment of a student section in the Journal, and encouragement of presentation of scientific papers at county, state, and even national levels, also to study the possibility of a student section of the scientific assembly

### WOMAN'S AUXILIARY

#### TO THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

#### Executive Board Coordinates Year's Activities

THE Executive Board of the Woman's Auxiliary to the Medical Society of the State of New York met on October 7 and 8 in Port Jervis to coor dinate the activities of the Auxiliary Mrs Harry F Pohlmann, State president, and chairman of various committees presented reports and made suggestions as to possible projects which the Auxil iary could adopt during the coming year Two of the current projects discussed were Physicians' Home and scholarships and loans for needy nursing students

The meeting opened with a modified conference of the county presidents, at which an informal discussion of the programs and projects of the year brought forth an interchange of ideas, pointed out the problems each auxiliary faced, and the methods and solutions undertaken. The net result of this meeting was to stimulate the county presidents to

active participation in the Auxiliary program.

Guest speaker at the dinner on October 7 which closed the first day's seesion, was Mr Loc B Mailler, majority leader of the State Assembly and chair-man of the Advisory Board and the Joint Hospital Survey and Planning Commission. He stated that an active constructive interest by women in the health of their community can go a great way toward solving the health problems of the State. proof of what can be done in small communities Mr Mailler, who is superintendent of the Cornwall Hospital, cited the accomplishments of the Citi zens' Public Health Committee organized last year by women in Cornwall. Establishment of immuni zation clinics raising of money for a new hospital, and a number of other services to the hospital are among the committees achievements, he stated.

Mr Mailler also spoke briefly of the maldistribution
of doctors in New York State saying that 'there are too many in the cities and too few in the rural areas.

At the morning session on October 8, Mr Thomas E. Walsh, of the Public Relations Bureau of the State Modical Society spoke on the need for Auxihary members to "determine whether or not their dootor husbands were participating in medical care plans. He emphasized the part they could play in pointing out the necessity of the individual doctor to laten to the voice of public opinion which is demanding some type of prepaid medical

Mrs. Harry Van Wagenen, State Commander of the Field Army of the American Cancer Society was a guest speaker at the luncheon session that day She stressed the vital need for continued awareness

of the cancer problem.

The National president-cleet of the Woman's Auxiliary to the American Medical Association, Mrs. Luther H. Kice, of Garden City was present at the meeting and was introduced to the group by

Mrs Pohlmann

Mrs Pohlmann
Also introduced were Mrs. Harold B John
son, of Buffalo recording secretary of the State
Auxiliary, Mrs. Fred G Jones, of Utica, treasurer
Mrs. Walter A. Schmitz of Middletown, cor
responding scoretary Mrs. Edgar M Neptune, of
Syraouse State president-elect Mrs. Thomas E.
Bullard of Schuylerville first vice-president Mrs.
John J Rainey of Troy second vice-president Dr
V J Hicks of Middletown, president of the Orange
County Medical Society Mrs. Frederick R. Small,
of Newburgh, president of the Orange County
Woman s Auxiliary Dr Theodore Neumann, of
Central Valley chairman of the Orange County
Advisory Council, and Dr Harry F Pohlmann
Several past-presidents also were introduced

Several past-presidents also were introduced Mrs J Emerson Noll, of Port Jervis Mrs. Carlton Werts, of Buffalo, Mrs Edwin A. Griffin of Brooklyn and Mrs. Alfred L. Madden, of Albany

### Schenectady Auxiliary to Hold Legislative Meeting

DR. JOSEPH S LAWRENCE, director of the Washington office of the Council on Medical Service, will be guest speaker at the Legislative meeting of the Auxiliary to the Schenectady County Medical Society on Thursday evening, November 20, at the Van Curler Hotel in Schenectady His subject will be "Medicine a Political Football All County Auxiliary members and their hus-bands are invited to the meeting. Following Dr Lawrence's talk, there will be an open forum.

### THE GUILTY ANOPHELES

The scientific and medical world observed a significant anniversary on August 25 this year That date marked the fiftieth anniversary of the discovery by Sir Ronald Ross that malaria parasites were to be found in a mosquite s stomach and that mosquites (Anopheles) therefore, were wholly responsible for spreading malaria throughout much of the world.

Sir Ronald, who was to win the Nobel prize for his important discovery was just a medical officer with the British Army when he found the long sought answer to malarial infection at Secunderabad, India, August 25 1897 Many important scientists, doctors, and others had tried to determine the cause of malaria but it remained for an obscure, hard-working Army doctor buried in the Indian hinterlands to come up with the right answer after years of effort.

Sir Ronald, however did not stop his work on malaria with the discovery of the mosquito s part. He plunged into the problem of proper medication, being one of the first to determine the right dosages of quinine. He urged, in proneering fashlon, that schoolmasters and other public servants be trained in urging children and adults to take quinine regu-

## ABSTRACT OF MINUTES OF THE COUNCIL OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

AT ITS meeting on October 9, 1947, the Council considered various matters, taking action or directing further study and reports, as indicated under the following headings

### Secretary's Report

Remission of State Assessments—The remission of State assessments was voted on account of service with the armed forces for 1 member for 1948, 682 for 1947, and 76 for 1946, also on account of illness for Drs Robert F Schanz and John P Schneble

Meetings—It gave your Secretary great pleasure, with Dr J Stanley Kenney, to represent the Medical Society of the State of New York at the Annual Meeting of the Medical Society of the State of Pennsylvania, at Pittsburgh, September 19, 20, and 21 Since then I have also attended the meeting of the Seventh District Branch at Bath, and the Eighth District Branch at Jamestown on September 25 and October 1, respectively Also on September 20, with Dr Hannon, I was present at a hearing conducted by Senator Feinberg at Albany in regard to a proposal to establish a new medical school as part of the proposed New York State University Dr Hannon's statistics helped much to show the legislators how little there is need of an added medical college in New York State I have also attended committee meetings and have kept up with correspondence

Dental Associations—Liaison Committees—Dr George F Lull, secretary and general manager of the American Medical Association, in his letter of September 15, 1947, urges state and county medical societies to have liaison committees working with the corresponding dental associations. I wrote Dr Lull that our society has such a committee. Do you wish to urge similar committees in the constituent

county medical societies?

After discussion,

It was voted that Dr Anderton write to each county society suggesting that it might be well for them to have a joint committee with dentists

Communications—Dr Bauer stated he had received a communication from the United Medical Service, Inc., regarding a dinner at the Hotel Biltmore on November 19, as a means of public notice on the progress of prepaid medical care and hospital insurance. Dr Charles Gordon Heyd will be Charman of the dinner committee, and Dr Bernard M Baruch will be the principal speaker. The United Medical Service and the Associated Hospital Service requested that the Medical Society of the State of New York be a sponsor for the dinner, without cost

It was voted to sponsor the dinner

### Treasurer's Report was Accepted

### Report of Executive Officer

Dr Hannon reported that he had attended the meetings as mentioned by the Secretary in connection with the proposed State University Medical School and the three District Branch Meetings that have been held, the Seventh, the Fifth, and the Eighth

### Activities of Committees

Committee on Legislation—Dr H Aranow, Chairman, stated that he intends to call a meeting of the committee as soon as the District Branch meetings are completed

Subcommittee on Cult Practices and Subcommittee on Legislation —Dr Maurice J Dattelbaum, Chairman, reported that two matters had been referred to the Subcommittee on Legislation one on medical technicians and one on podiatrists, and they had reached the following conclusions

"For medical technicians a two-year course of instruction is sufficient if the schools that give such a course are authorized and approved by the proper authorities. A four-year course is not necessary, as there probably would not be enough students to take it. We are not opposing the four-year course as such, because we think that if there are any medical technicians that want a degree and desire to advance themselves, they should be encouraged to do so."

As to the podiatrists, at the committee meeting we were shown a catalog from the Long Island University. This has nothing to do with the Long Island College of Medicine. They are entirely separate and distinct organizations. At the Long Island University a four-year course has been in augurated for podiatrists. We found in the booklet the names of eminent specialists in Greater New York who are asked to give lectures there, so we felt a questionnaire sent to those lecturers would give us information as to whether we should or should not oppose the podiatrists' expanding the field of podiatry. In the proposition, the podiatrists are asking to be permitted only to treat systemic diseases, but we added the word "diagnosis" to make it read "the diagnosis and treatment of systemic disease." We feel the privilege of treatment should not be granted without their knowing something about diagnosis.

Dr Anderton has sent out this questionnaire, and he has some answers. All except one have stated that they feel the course in podiatry should not be four years. They all state that they have lectured at the Podiatry Institute on a few occasions at the request of the head of this Institute, without re-

muneration

Committee on Economics, Subcommittee on Medical Expense Insurance —Dr Carlton E Wertz, Chairman, referred to the following report of the Director of the Bureau of Medical Care Insurance

Director of the Bureau of Medical Care Insurance
September 20-23, 1947 Mr Farrell attended the
second Annual Conference of the Associated
Medical Care Plans at St Louis Recommendations
regarding all phases of the functions of medical care
plans were introduced by the special committees as
follows

Physician Cooperation

Barrett A Nelson, M.D., Chairman, reported that an analysis of problems was divided into the following factors

"1 The average physician does not understand how his own plan operates

"2 The fee schedule must provide satisfactory compensation for medical services rendered

"3 It is important that the administration of claims and payments to physicians be subject to medical interpretation

"4 The doctor becomes irritated with outside arrangements which tend to interfere with his

physician-patient relationships
"5 The feeling frequently arises that the plan
discriminates between urban and rural physi-

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cians

Lack of discipline in the ranks of the medi

cal profession Restrictions in contracts invite abuse and

"9 Economic conditions at the moment tend

misunderstanding "8 A minority element within the medical

profession are dishonest

to lessen the amount of real interest in the average medical care plan 10 Demand for osteopathic participation. "Ī1 Special consideration demanded by the

specialist groups.

12 The physicians' secretaries need to be

- plan. 13 Physicians' lack of understanding of the elementary principles involved in the field of medical economics.
- '14. Physicians fear that fee schedules will tend to reduce the level of fees in private prac-
- 15 Physicians object to a third party setting fees for medical service.
- 16 Little opportunity for training in medical economics afforded by the average medical school "17 Income limits for service benefits create confusion.
- "18. Many doctors resist any sort of inter ference with his private practice of medicine
- The doctor fails to read material which is 19 directed to him through the mail.
  - 20 Doctors resist paper work and forms Physicians often agree to participate in a "21

medical care plan as a choice between the lesser of two evils.

Doctors too often fail to appreciate the devicus, and sometimes subtle processes through which public opinion is formed The shaping and controlling of public opinion is a skilled art beyoud the reach of most men. Careless remarks with individual patients may ultimately be translated into adverse public opinion because individual patients belong to groups and the plan deals primarily with organized groups of enrolled persons. Lack of cooperation which is com-mitted innocently is the most difficult of all problems to eradicate.

Recommendation That AMCP initiate an adequately conceived study capable of probing beyond mere statements of fact which would result in the accurate determination of reasons causes underlying fears and explanations for the existence of facts which are observable but not thoroughly understood.

Departments of Physician Relations Established in Local Plans

Recommendation That AMCP seek to further establish of a Department of Physician Rela tions within each of its member plans.

"That the Director's office be instructed to proceed with preparation of a brochure which is the result of methods used in various plans and which might serve as a working tool to be used by AMCP member plans in the establishment of such departments—this brochure to be used for dis-semination of such information to the member plans and to which might be added, periodically results of studies initiated by this committee.

### Cooperation from Medical Societies

Recommendation The acceptance of the following statement of principle

"It shall be recognized that the responsibility for maintaining physician cooperation must be shared by plan management and the sponsoring medical society, that while management shall be held responsible for furnishing full information to the medical profession regarding its operations and development, the responsibility for gaining professional acceptance of the philosophy and principles of prepaid medical care shall rest essentially with the physicians and their organized societies and further, that the financial support of programs designed to pro-mote better physician relations shall also be shared.

#### Cooperation from the A.M A

"Recommendation That AMCP Commission encourage the Council on Medical Service and other offices of the A M A to continue active coopera tion toward furthering physician cooperation

#### Assistance from AMCP

"Recommendation That AMCP establish a list of qualified physicians, willing to accept speaking engagements on invitation of both plan management and sponsoring medical society

That AMCP prepare visual presentations of in formation, such as slides and filmstrips for use by member plans in furtherance of better physician relations that AMCP produce effective literature for use by member plans in distributing pertinent information to physicians that AMCP prepare exhibit material in such form as might be utilized by member plans in planning exhibits for medical society meetings etc and to furnish general field service in the development of physician relations programs and that a qualified person be added to AMCP staff for this work

### Case Procedure—Charles G Hayden M D Chairman

Standarduration of Statistical Data

Recommendation That it favors the accumu lation of experience data necessary for a scientific actuarial study

#### Recoprocity of Benefits

That the Committee ex 'Recommendations plore fully the Inter Plan Service Bank proposal currently being developed by Blue Cross Commission, to determine whether the basic proposal could be adapted to reciprocity of medical benefits that the following principles be observed

'1 Payments to physicians should remain identical to the fee schedule in effect in the plan with which physician is participating regardless of

fee schedule used by patient s home plan

2. The home plan should pay for services rendered at its own too schedule rate regardless of the fee schedule used by the plan in whose area service is rendered.

#### Employment of Medical Director

Recommendation That AMCP staff member be employed to work in the field of case procedure preferably a physician with proper qualifications and experience in medical care plan administra tion.

#### Enrollment Committee-Harley West Temporary Chairman

Recommendation from Reciprocity Committee That AMCP recognize the urgent need for a uniform contract to facilitate enrollment of national accounts"

### National Accounts

"Recommendation That AMCP give final approval and objectives be worked out cooperatively between AMCP and the Blue Cross"

### Community and Rural Enrollment

"Recommendation That AMCP commend and encourage the Council on Medical Service of AMA in establishing community health councils and that AMA Board of Trustees approve what the Council hoped to accomplish and that AMCP advise member plans regarding the Council's project as soon as Council receives official approval to proceed",

## AMCP Studies on Community and Rural Enrollment

"Recommendation That AMCP expand amount of information now on hand by conducting a thorough study of all aspects in community, rural, and individual enrollment"

#### Personnel

"Recommendation That AMCP make provision for adequate personnel to render service to its member plans in the field of enrollment"

### Research Studies—Jay C Ketchum, Chairman AMCP Depository of Studies

"Recommendations That AMCP circularize all sources, to determine what surveys, studies, or data had been developed, that such studies regardless of limitation be collected in Chicago office, catalogued and made available to member plans, that AMCP request tabulating sections in the new district organizations to work out uniform methods for maintaining minimum statistical information pertaining to membership which shall be kept by each plan.

That AMCP request the claims department sections in the new district organizations to work out uniform diagnostic and/or experience codes to be used by each plan in recording experience data, that accounting sections in district organizations work out uniform methods of financial reporting for use of plans in reporting to AMCP."

### Reciprocity—A. J Offerman, M.D., Chauman Membership Transfers

"Recommendation That the presently established Blue Cross Inter-Plan Transfer and Branch Office Enrollment Agreement be adopted immediately by as many AMCP member plans as possible Agreement in part is herewith reproduced

"(A) To accept as participants the paid-up subscribers from other medical service plans who establish residence in our enrollment area, without regard to local group enrollment requirements

regard to local group enrollment requirements "(B) To recognize the previous continuous enrollment period in another plan (or plans) as the basis for meeting any waiting period requirement for benefits in our plan

"(C) To accept branch office or local employed groups of out-of-town organizations, when smaller in number than regular minimum group requirements, provided enrollment of the home office employees is proceeding, or has been effected, through another medical service plan

"(D) To accept branch office or local employed groups of out-of-town organizations, which by numbers qualify under minimum group requirements at percentages of 50 per cent or more, waiving the enrollment percentage requirements of the local plan, provided enrollment of the home office employees is proceeding, or has been effected, through another medical service plan"

### National Enrollment

"Recommendation That AMCP recommends early and immediate attention to the problem of establishing a uniform contract for enrollment of national accounts, together, with uniform practices for billing and collecting and that the Committee's efforts be correlated with Blue Cross National Enrollment committee, and finally, that AMCP Enrollment Committee give consideration to the possibility of sharing in the support and cost of a national enrollment office in cooperation with the Blue Cross Commission."

### AMCP-Blue Cross Joint Committee—Frank Feitra bend, Md, Chairman

"Recommendations That Associated Medical Care Plans, Inc , establish Plan district organizations equivalent to the present Blue Cross districts,

"That AMCP and Blue Cross Plans work to-

gether on a district basis,

"That the committee refer, through the respective Directors of each, agenda items for the joint session of the AMCP and Blue Cross Commissions at St Louis"

The following recommendations of AMCP Public Relations Committee were considered

"I That the words 'Blue Shield' and the Blue Shield emblem be adopted as the official symbol of AMCP member plans, and that AMCP register the above-mentioned name and design with the U.S. Patent Office,

"2 That the Blue Cross Commission be requested to devote regular space in the Blue Cross Bulletin to news of nonprofit medical care plans, detailed arrangements to be worked out by

Directors of each Commission, and
"3 That Director of AMCP be requested to
proceed with the further factual investigation of
the publication of a National Health Magazine,
and that AMCP Commission be advised of the
proposal for such a publication and the Committee's action in that regard"

## Finance Committee—Norman M Scott, MD, Chairman

"Recommendation And the Commission approved, that the By-Laws of the Association under Chapter III, Section I, (a) be amended to read as follows

(a) Full Members Monthly rate of 1 mill per beneficiary covered by contracts in force, minimum \$10 per month, maximum \$500 per month

Recommendations by all committees were accepted by the AMCP Commission except the recommendation of the Finance Committee This report was amended to read as follows "Full Members—Monthly rate of 2 mills per contract per month on contracts in force, minimum \$10 per month, maximum \$500 per month."

In adopting the recommendations of the special committees the AMCP is taking a practical and con-

structive approach from a local to a national level in promoting voluntary nonprofit medical care plans

There are over forty medical cure plans approved for membership by AMCP and it is the recommendation of Mr Farrell that New York State Medical Care plans which have not done so apply for membership in order to participate in the benefits of membership and have a vote in the formation of its policies

September 20 1947 Mr Farrell attended the Seventh District Branch meeting of the Medical Society of the State of New York at Bath NY, and arranged at that time with the Legislative Com mittee of the Steuben County Medical Society to meet with them on October 9 1947 to discuss a report recommending endorsement of a medical care plan

The report was accepted

Committee on Questions on Ethics.-Dr James R. Reuling, Chairman reported that there had been referred to the Committee on Questions on Ethics material in regard to a suit instituted against the N 1 State Society of Pathologists by a commercial laborator. The pathologists desire to have the Medical Society of the State of New York participate in this action as they feel that the suit challenges all our organized groups

After discussion.

It was roted that the Council approve of having the Secretary of the Medical Society of the State of New York write to the Secretary of the pathologists organization and suggest to him that we have a joint committee to study mutual problems and to iron out any differences so that we could present a united front on the subject of medicine as a whole this Committee to be a Subcommittee of the Economics Committee

Hospital Association of NY and Medical Society of the State of NY , Joint Committee. - Dr Carlton E. Wertz Chairman reported that Mr Clearwater met with the Attorney for the Joint Council representing the specialists of pathology roentgenology, anesthesiology and physical therapy. He stated that there would be a meeting in the near future with the hospital group and thought it would be wise if we express certain broad principles, and then proceed to straighten out the association between the doctors and the hospitals He recommended that the Council accept the following principles with the idea that they will be broadened, enlarged and additions made

'(1) It is agreed that the practice of Pathology Anesthesiology Rocatgenology and Physical Therapy are medical services and the practice of

medicine

(2) That these specialties are so recognized
(3) That an equitable arrangement can be made between the individual hospitals and the doctors who practice these four specialties recog nizing the above principle, whereby the hospital may bill for services in the name of the person rundering them. (This can be done by inserting the name on the regular hospital billhead ic. Instead of Nay indicate Professional Services of Dr Roentgenologist, )

After discussion,

It was roted that we rolterate our approval of these principles relative to the four specialties as being the practice of medicine,

Committee on Office Administration and Policles.—In the absence of the Chairman, the Secretary reported verbally that the Committee had mot October 8 1947 and transacted routine business particularly as applied to the salaries of a number of employees

Planning Committee for Medical Policies .- Dr J Stanley Kenney Chairman reported that there were two things that were principally engaging the attention of the Committee at the moment-the resolution referred at the last meeting relative to the reorganization of the District Branches on the request of Rockland County and the Group Practice resolution which was referred back to the Planning Committee In this connection, there was to be a meeting the following day with Dr Dickinson, the bead of the Bureau of Economic Research of the American Medical Association, Dr Edward Cun niffe, Dr Kenney and several members from the Group Health Council

He stated he had attended in Chicago hat week a conference of the National Physicians Committee and thought it was one of the most extraordinary medical gatherings that he had ever attended New York State had at that meeting Dr Conrad Berens Dr Roy Henline, Dr Herbert Bauckus and Dr Kenney It was attended by about 162 physicians from the 48 states Alaska Hawaii and by some 40 dentists by the members of the Medical Service Foundation, their officers and board of directors the Trustees of the National Physicians Committee and many of the past and current officers of the American

Medical Association.

Committee on Public Health and Education,— Dr O W II Mitchell Chairman, reported as fol lows

September 16, 1947 Attended a meeting of the Council Committees on Public Health and Education and Legislation and the Joint Subcommittee on Physical Medicine held in New York City

October 8, 1947 In New York City attended a meeting of the Council Committees on Public Health and Education and Lonalation and tho Joint Subcommittee on Physical Medicine. The State Education Department was also represented at this meeting

October 17, 1947 In New York City attended a meeting of the Council Committee on Public Health and Education and the Subcommittee on Cancer Invited to attend this conference were some of the officers of the Medical Society of the State of New York and representatives of the State Department of Health.

October 21 1947 In New York City attended a meeting of the Council Committee on Public Health and Education and the Subcommittees on Maternal Welfare and Child Welfare. The Child Consulta tion Clinics and the proposed additional films on obstetrics for postgraduate medical education were considered at this conference.

Also on this same day in New York City, there was a conference of the Council Committee on Public Health and Education and the BCG Ad-

visory Committee

Invited to attend these meetings were some of the officers of the Medical Society of the State of New I ork and representatives of the State Department of Health.

Committee on Public Health -A meeting of the Joint Subcommittee on Physical Medicine Charles M Allaben, M.D Chairman—was held in New York City on September 16, 1947 Members of the Council Committees on Public Health and Educa tion and Legislation were present as were some of the officers of the Medical Society of the State of New York. The qualifications and licensing of physictherapists were considered at this meeting

result of the discussion, a tentative resolution was drawn up with reference to qualifications required of physical therapists in New York State, and referred to the Council for study to be taken up at a later meeting

Postgraduate Education -Postgraduate instruction has been completed in Cayuga, Nassau, Ostego,

Sullivan, and Warren counties

Postgraduate instruction has been arranged for and will be given in the following counties Broome, Clinton, Cortland, Jefferson, Ontario, Orange, Oswego, Schenectady, Schoharie, Seneca, Tompkins, and Wayne

Arrangements have been completed for a Teaching Day to be given in Monroe County on Novem-

ber 13, 1947

A request for a series of twelve lectures has been received from the Richmond County Medical Society When subjects and speakers are decided upon, the Committee will proceed with arrangements

The report was accepted

Subcommittee on Nutrition -Dr Bauer reported that he had had a telephone call from Dr Herman Hilleboe, State Commissioner of Health The Governor has appointed him chairman of a Committee on Nutrition to cooperate in the nationa food conservation program. He stated that Dr Hilleboe would appreciate having a subcommittee from the State Society under Dr Mitchell's Committee on Public Health and Education to co-operate with this general State committee After consultation with Dr Mitchell, he suggested the following names

Dr Norman S Moore, Chairman, 512 East

State Street, Ithaca
Edgar C Beck, M D, 333 Lanwood Avenue,
Buffalo 9, assistant professor of medicine and therapeutics, University of Buffalo, School of Medicine

Elaine P Ralli, M D, 138 East 36th Street, New York 16, associate professor of medicine, New York University, College of Medicine Norman Jolliffe, M D, 39 East 75th Street, New York 21, associate clinical professor of pre-ventive medicine, New York University, College of Medicine

It was voted that Dr Mitchell be given authority to designate a Chairman of the Subcommittee in case Dr Moore would not accept

Dr Anderton was requested to notify Dr Hilleboe that the State Society through its Council has appointed this Subcommittee on Nutrition Committee on Public Relations—Dr

Winslow, Chairman, read the following report

It is requested that the Council ask the Board of Trustees to appropriate for the use of the public Relations Bureau an additional sum of \$3,201 15 which represents emergency and unexpected outlays in the spring of 1947 for which there was no budgetary allowance

Expenditures of the Public Relations Bureau to date have been about equal to the proportionate budgetary allowance Therefore, unless this ad-ditional money can be obtained, it will be impossible to be in sufficient funds to publish phamphlets planned. They are

planned

A handbook descriptive of the activities of the Medical Society of the State of New York

Pamphlet describing the awards which were given at the 1947 annual meeting at Buffalo to 400 physicians who had practiced medicine for fifty years or more Photographs have been obtained

from practically all these men, and miniature bi The cost of printing ographies have been written this document, proposals for which have been re-ceived, will be \$3,275 00 We are already in receipt of many letters from these physicians inquiring when the document is to be published. They and their friends are looking forward to receiving it with great interest

Mr Thomas E Walsh attended district branch meetings at Bath, Utica, and Jamestown continued his investigation of the feasibility of speakers' bureaus in connections with these and other

field trips he has made

Releases regarding postgraduate education were sent concerning the activities of the Committee on Public Health and Education to newspapers in the following counties Clinton, Cayuga, Cortland, Nassau, Seneca, Tompkins, Warren, and Geneva Academy of Medicine

It was voted that the report of the Public Relations Committee be accepted, carrying with it the recommendation for an additional appropriation to the Board of Trustees

Committee on Publication -Dr George W Kosmak, Chairman, reported that the Publication Committee had had its regular meeting on October 8, 1947, and considered many routine matters

In view of the enormous amount of material on hand awaiting publication, both in the way of scientific papers, council matters, etc., the Committee deemed it desirable to increase the Journal by at least one additional form, and have secured the paper at the price of 141/2 cents a pound instead of

The question of certain advertising was discussed, and the Committee is proceeding with further studies to develop just what is meant by "undesirable and unethical advertising" as stated

at the last meeting of the Council.

The matter of Dr Thomas Halsted's advertisement was discussed, and it was decided to notify him that as this type of advertising is considered illegal, it will

have to be omitted from the JOURNAL

The Directory was discussed, and the next issue is ider way. Copies of the 1947 edition have been under way distributed to all members

Liaison with the Veterans Administration —Dr Herbert Bauckus, President of the Board of Directors of the Veterans Medical Service Plan of New York, Inc , reported that there had been a meeting of the Board on October 8, 1947, with representa-tives from New York State of the Veterans Ad ministration, including the new branch medical director, Dr Ethan Flagg Butler

"During the eleven and one-half months that the plan has been in operation, 188,961 authorizations were granted, for which the amount obligated was \$5,146,888 The amount of money actually paid, however, was about 20 to 25 per cent less authorizing physician allows an amount that is not always used

"There has been a considerable change in the handling of much of this work in that more and more of it has been diverted to the Veterans Administra-

tion clinics

"When this plan went into effect last September there were many veterans in need of treatment, and the Veterans Administration did not have the facilities or personnel to take care of them So they urged us to hurry our program, which we did In the month of October, which was the first full month last year, there were 11,000 authoriza tions and \$159,000 obligated, then it went up so

that in March there were 23 000 authorizations with \$643,000 obligated. Then it began to decrease the next month when there were 18,000 authorizations and the smallest amount we had was in August with 13,359 authorizations and \$320,000. That represents in part the fact that many of these veterans have been taken care of, and the case load should go down

"There is another thought about that and that is when this program eventually goes over into the Veterans Administration clinic care, which I think is bound to come it will be shown how much this cost originally under our plan and how little money they were spending for it two years later The obvious comparison to the public and their understanding will be that we have cost the Government a great deal of money in taking care of patients under this

"The reason I mention this point is that yesterday the former branch medical director stated several times that he thought that the clinic method of care had a superiority over our private care system. He is quite committed to that, and that type of leader ship, I think, has harmed a great deal the private care for the veteran in this State in the past year Furthermore he said that Veterans Administration will take care of all of neuropsychiatry in the New York area in the clinics beginning the first of January This is an order that he sent out just the other day For one thing it is going to be a great deal cheaper, some \$500,000 a year less than they figured will be the cost here in the metropolitan area. This branch is taking in the immediate metropolitan area and some of the outlying counties under the supervision of our Coordinator in this area. Dr. O Kane

I want to report to the Council that the panel of neuropsychiatrists taking care of these patients—about 600 of them are the active ones—have been told beginning October 1 no new authorizations will be made, and they should expect to have all private

care treatment terminated by January 1

Then there is another item you should know The American Medical Association has called a conference of representatives from all the states for November 6 in Chicago A program will be presented, and there will be representations from various groups in the states Many, I understand, are very dissatisfied with this program.

A Committee in the American Medical Associa tion having to do with the study of this veterans medical care problem is to meet November 5 American Medical Association, through its Council on Medical Service has charge of this and Dr McVay the Chairman has invited each state to have representation. At this mooting General Hawley will present the main topic in the afternoon.

There is one other thing I should mention. We renewed the contract with our Veterans Administration for another year, so that it has practically another year to run. It was renewed on the same terms as the old contract but in my opinion there have been many violations of that contract or at least in the tenor of them, so that it really does not matter so very much except for two things. One is the establishment of the proper fee schedule, and the other is that under this system the coordinators, the physicians who are employed to look after the quality of the work, have a very important job They have done a good job and we can be very proud of our accomplishments in caring for the veterana

The question of the fee schedule was discussed and Dr Butler thought that we ought to have a re-

vision of it, and that we ought to have two fee schodules in N Y State one upstate and one downstate There was also interjected into the discussion the idea of the National Fee Schedule which the Veterans Administration have put out as a sort of maximum fee schedule for all states

We stated that we had gone through this question of fees very thoroughly, and as far as we could make out the fee was all right and was the same as was usually charged by the private practitioner but that we would appoint a committee and again go over the entire ice schedule and talk with the Veterans Administration about it afterward We also stated that this fee schedule has been agreed to by the Veterans Administration It is the Veterans Ad ministration fee schedule as much as it is ours. We went over it many times with them, and we agreed to make revisions when it was shown by them that they were necessary In order to get the men to do the work we felt we should have this fee schedule as outlined, so when it comes to that question it is as much the obligation of the Veterans Administration as it is of the Veterans' Medical Service Plan of New

lork or of the physicians generally

It was roted that the Council go on record as

favoring one fee schedule for the State Committee on Workmen's Compensation -Dr

J Stanley Kenney submitted the following report.

Arbitration Proceedings Arbitration proceedings were held in Albany Utica, Rochester, and Buffalo

from June 24 to June 27, 1947

An increasing number of physicians who have signed arbitration forms and agreed to appear at the arbitration sessions have failed to appear We have made every effort to assure the attendance of physicians. In some instances where it was impossible for the physician to attend and our office was notified well in advance, we consented to represent the physician if it appeared that the necessary medical information could be obtained, and if the physician agreed in writing to abide by the results of the arbitration In spite of this we have noticed an increasing tendency on the part of certain physicians to fail to put in an appearance without notifying us Every effort should be made to impress upon physicians the importance and seriousness of arbitration proceedings and the necessity of their attend

Legislation The Bureau has prepared legislation to amend the Workmen's Compensation Law and to add to it for submission to the Committee on Legislation. It is hoped that this year legislation recommended by the Committee and approved by the Council will be ready for presentation as soon as the Legislature convenes.

Radiology An examining Committee in Radiology has been appointed in Albany to examine a candidate for radiologic rating from Albany County A radiologic examination will be held at New York University X ray Department on October 7 when five candidates will be examined

Chemung County Round Table Meeting Director acted as moderator at a round table discussion on Workmen a Compensation in Limits on September 17 1947 Among those participating in the meeting was the vice-chairman of the Workmen s Compensation Board Frank D Maurin, who subsequently sent the following letter to your Directory

It was a pleasure to have participated with you in the Workmen's Compensation Forum sponsored by the Chemung County Medical Society and for which you acted as moderator Such activity is most desirable and informative

"Kindly accept my congratulations upon your

efforts in this most worth while activity

"With warm personal regards, I am "
New Fee Schedule Your Director has received from the assistant counsel of the Workmen's
Compensation Board the following memorandum
concerning the interpretation of certain items in the
new fee schedule

new fee schedule

"With regard to the increased medical fee schedule that became effective June 1, 1947, the Advisory Committee in recommending the increased schedule to the Chairman, representative as you know of all parties in interest, had in mind that the increased fee should be applicable to those cases in which medical care began on or after June 1, 1947. Where a claimant did not receive any medical care before June 1, 1947, the increased fee schedule is applicable regardless of date of accident.

"In a case where treatment began prior to June 1, 1947, and a new doctor is called in after June 1, 1947, the old fee schedule nevertheless is applicable. Compared with the number of increased fees, these cases would be relatively few."

Anesthesia Fees. An anesthetist in Elmira was requested to pay to a hospital in Elmira, where he had anesthetized a workmen's compensation claimant, a fee to cover the cost of anesthetic drugs used. In answer to the physician's inquiry we have replied that there is nothing in the fee schedule which permits or directs a physician to refund any part of his fee for the cost of the anesthetic drugs supplied in the hospital. It has not been customary for the hos-

pitals to charge physicians for such drugs
According to a statement made by a member of
the Hospital Association Committee on Arbitration,
the fee of \$20 or \$15 which the hospital receives for
the use of the operating room includes the anesthetic
Furthermore, a physician is entitled to charge for the
use of drugs, biologicals, sera, etc., in addition to the
fee for medical service. For example, if a physician
uses tetanus antitoxin or penicillin, he charges his
medical fee plus the cost of the drugs used and it is

customary and in accordance with the fee schedule for the employer or insurance carrier to pay these charges. Therefore, physicians should be on their guard in allowing any refunds to the hospital for the use of anesthetic drugs. The employer is liable for all medical care, drugs, etc., and if the agreement with the Hospital Association for the use of the operating room does not include the providing of the anesthetics, then the employer or insurance carrier would be charged not only for the scheduled fee for the induction of anesthesia but also the cost of the drugs.

mduction of anesthesia but also the cost of the drugs Meetings Dr Kenney stated that during the summer he called on the chairmen of the County Society Workmen's Compensation Committees in Buffalo, Syracuse, Rochester, Ithaca, and Schenectady He was much impressed with the organization in Eric County He had two meetings with the Chairman of the Workmen's Compensation Board, and has an appointment for another meeting with her next week. Through Dr Bauer's kindness he attended the Pennsylvania State Society meeting. There he had an extensive talk with Dr Laverty of Harrisburg in connection with Workmen's Compensation in Pennsylvania.

One of the functions of our Committee on Work men's Compensation this year will be to try to effect a close huison with the individual counties and get them to comply with the provisions of the law, particularly as to the filing of reports

"There is an apprehension in certain parts of the state as to the extending activities of the Medical Practice Committee, which supervises the workmen's compensation work in four metropolitan counties. This is particularly true in Erie because they are not far from the one million population mark, and if they should cross it they would automatically come under that Medical Practice Committee

"I hope that this year in conjunction with our Legislative Committee something can be done to break down that, and legislation can be passed to abolish the Medical Practice Committee

World Medical Organization.—Dr Louis Bauer reported that the World Medical Association was organized last month in Paris, France

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### **BOOKS**

Books for review should be sent to the Book Review Department at 1313 Bedford Avenue Brooklyn N Y Acknowledgment of receipt will be made in these columns and deemed sufficient notification. Selection for review will be based on merit and interest to our readers.

### RECEIVED

Clinical Practice in Infectious Diseases For Students, Practitioners and Medical Officers By E H R. Harries, M D, and M Mitman, M D Third edition Octavo of 679 pages, illustrated Baltimore, Williams & Wilkins Company, 1947 Cloth, \$600

Textbook of Medicine By Various Authors Edited by Sir John Conybeare, DM (Oxon) Eighth edition Octavo of 1,170 pages, illustrated Baltimore, Williams & Wilkins Company, 1947 Cloth, \$8 00

Gynecology With a Section on Female Urology By Lawrence R Wharton, M D Second edition Octavo of 1,027 pages, illustrated Philadelphia, W B Saunders Company, 1947 Cloth, \$10

Biochemistry of Cancer By Jesse P Greenstein, Ph.D Octavo of 389 pages, illustrated New York, Academic Press, 1947 Cloth, \$7 80

Curare Its History, Nature, and Clinical Use By A. R. McIntyre, M.D. Octavo of 240 pages, illustrated Chicago, University of Chicago Press, 1947 Cloth, \$5 00

P-Q-R-S-T A Guide to Electrocardiogram Interpretation. By Joseph E F Riseman, M D Second edition Oblong twentyfourmo of 84 pages,

illustrated New York, Macmillan Company, 1947 Cloth, \$3 50

Office Immunology, Including Allergy A Guide for the Practitioner Edited by Marion B Sulzberger, M D, and Rudolf L Baer, M D Octavo of 420 pages, illustrated Chicago, Year Book Publishers, 1947 Cloth, \$6 50

The 1946 Year Book of Neurology, Psychiatry, and Neurosurgery Neurology edited by Hans H Reese, M D, and Mabel G Masten, M D Psychiatry edited by Nolan D C Lewis, M D Neurosurgery edited by Percival Bailey, M D Duodecimo of 732 pages, illustrated Chicago, Year Book Publishers, 1947 Cloth, \$3.75

Les Methods de Choc et Autres Traitements Physio-Pharmacologiques Dans Les Maladies Mentales By Marcel Pahmer, M.D. Octavo of 95 pages Paris, France, Le Francois, 1946

History of the American Medical Association 1847 to 1947 By Morris Fishbein, M.D. With "The Biographies of the Presidents of the Association" By Walter L. Bierring, M.D. Octavo of 1,220 pages, illustrated Philadelphia, W. B. Saunders Company, 1947 Cloth, \$10

### REVIEWED

A Surgeon's Domain By Bertram M Bernheim, M D Octavo of 253 pages New York, W W Norton & Company, 1947 Cloth, \$3 00

Dr Bernheim describes the trials and tribulations of the surgeon from the training of the neophyte to the finished product Included are his own various experiences. He discusses his theories for the correction of the evils of medical practice. This volume may be of interest to the laity

RALPH WOLFE

Radiology for Medical Students By Fred Jenner Hodges, M.D., Isadore Lampe, M.D., and John Floyd Holt, M.D. Octavo of 424 pages, illustrated Chicago, Year Book Publishers, 1947 Cloth, \$6 75

This book admirably fulfills its purpose to supply medical students with all the knowledge a physician needs if he wishes to make the best possible use of diagnostic and therapeutic radiology. The book is mindful of the limitations and the dangers of the procedures. The text is concise, the language is clear, the illustrations are numerous and of superbiguality, the selection of the material is masterly. Its clarity, completeness, and accuracy render it highly recommendable to teachers and students alike.

S W WESTING

Pathology of Tropical Diseases An Atlas. By J E Ash, Col , (MC), USA, and Sophie Spitz, (MC), A U S Quarto of 350 pages, illustrated Philadelphia, W B Saunders Company, 1945 Cloth, \$8 00

This atlas covers those tropical diseases which are important from a military as well as a civilian practice. The authors stress the pathology of the conditions treated and present the material in a style which appeals greatly to the general pathologist. Despite its conciseness, the atlas is lucid and full of information of value not only to the pathologist, but also to the epidemiologist and clinician. The illustrations and diagrams are numerous and excellent. It is a prize volume for a medical library.

S. H. Polayes

Manson's Tropical Diseases A Manual of the Diseases of Warm Climates. Edited by Philip H Manson-Bahr, M D Twelfth edition Octavo of 1,068 pages, illustrated Baltimore, Williams & Wilkins Company, 1945 Cloth, \$12

This twelfth edition of so well-known and thorough a treatise on the diseases of the tropics should need no words of introduction or commendation to the medical profession. The book is profusely illustrated and the presentation of the subject matter leaves little, if anything, to be desired. The approach is clinical, but the discussion of laboratory aids to diagnosis is not neglected. Two chapters are devoted to consideration of "Life in the Tropics" and the criteria of physical fitness which should be methy those who contemplate working in tropical stations. The inclusion of these chapters seems worthy of note, since the subject not infrequently has been overlooked in other similar books.

[Continued on page 2482]

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\*Hincheun, S. R. N. Y St. Jr Med., 47 1367-9 June 15, 1947

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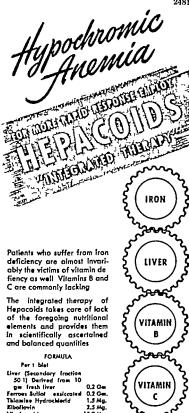
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[Continued from page 2480]

Postgraduate Obstetrics By William F Mengert, M D With drawings by Ruth Maxwell Sanders Octavo of 392 pages, illustrated New York, Paul B Hoeber, Inc , 1947 Cloth, \$500

The author reviews all phases of obstetrics, paying particular attention to those complications prone to confront the busy family doctor. Each subject is discussed in a thoroughly competent and concise manner. The ideas expressed are in keeping with a conservative, sane practice of obstetrics. The book is well printed, on fine paper stock, and the medical illustrations and photographs are well chosen, well rendered, and clearly reproduced.

Intrauterine douching to control postpartum bleeding or to remove any remaining fragments of a hydatid mole is no longer used in this region and one might question the advisability of recommending such a procedure to the casual intrauterine manipula-

This book fills a definite need for the busy general practitioner, bringing him in "capsule" form the current, accepted views on obstetrics

M GLASS

Gynecological and Obstetrical Pathology With Clinical and Endocrine Relations By Emil Novak, M D Second edition Octavo of 570 pages, illustrated Philadelphia, W B Saunders Company, 1947 Cloth, S7 50

In this second edition, the author has added the newer contributions to gynecologic pathology along with their references, thus bringing the book up to date. Occasional important correlations between pathology and symptomatology or therapy are included. The sections on carcinoma of the cervix and cyclical changes in the endometrium, Fallopian tube, and ovary are particularly complete and profusely illustrated. Recent contributions to our knowledge of the Brenner tumor and the feminizing mesenchymomas of the ovary are described in detail

Dr Novak's long experience as a gynecologic pathologist and teacher makes the text particularly valuable. The book is not encyclopedic. It should be of practical value to the student, clinician, and bacteriologist.

ALEXANDER H ROSENTHAL

Selective Job Placement. A Plan for Promoting Personnel Proficiency By Tobias Wagner, Ph D Octavo of 151 pages, illustrated New York, National Conservation Bureau, 1946 Cloth, \$2 50

The author summarizes extensive studies of comparative work-efficiency of physically disabled and normal persons in a wide variety of jobs in many industries and concludes that the performance of properly placed disabled people is as good or better than that of average employees

He contends that more selective placement procedure would increase greatly the job-effectiveness of all workers and he proposes a plan for ascertaining the individual differences of people and for determining the specific demands of every job to secure a

better balance between them

J J WITTMER

Free Medical Care Compiled by Clarence A Peters Duodecimo of 378 pages New York, H W Wilson Company, 1946 Cloth, \$1 25 (The Reference Shelf)

This short volume provides an excellent presentation of the arguments pro and con in the discussion of medical care, private and governmental, individual and cooperative. The "bricf" and the bibliography should prove valuable aids to the debater on the subject

BENJAMIN M BERNSTEIN

Military Neuropsychiatry [Res Publ Ass Nerv Ment Dis, Vol 25] Ed Bd, Col Franklin G Etaugh, MC, Chairman Octavo of 366 pages, illustrated Baltimore, Williams & Wilkins Company, 1946 Cloth, S6 00

This book comprises 32 chapters dealing with the emotionally sick servicemen of the second World War. It is a record which posterity may well consult in understanding the various forms of psychiatric disabilities that have occurred in the war, and may well be used as a guide for treating similar disorders arising in civilian life. It is a splendid book, dealing with an important subject, and will be of tremendous value for all who are concerned with the various forms of abnormal behavior, not only incliental to war but also found in civilian life. It is highly recommended

IRVING J SANDS

Diagnosis and Treatment of Menstrual Disorders and Sterility

By Charles Mazer, M D, and S Leon Second edition Octavo of 570 pages, illustrated New York, Paul B Hoeber, 1946 Cloth, \$7.50

This second edition is comprehensive. Although written for the family physician, it is difficult to see how it would help him, except for the excellent list of commercial endocrine products. Primary dysmen orrhea is the same old problem. Study of infertility is hardly a field for the general practitioner. The new chapter on the Rh factor and toxemia is very sketchy. The book is handsomely bound and well illustrated.

CHARLES A. GORDON

Dentistry An Agency of Health Service By Malcolm Wallace Carr, DDS Octavo of 219 pages New York, Commonwealth Fund, 1946 Cloth, \$1 50

Dr Carr has given us the first over-all survey of dentistry in the United States He presents the historic development of the profession, the educational status, going thoroughly into the prodental educational requirements and the postgraduate opportunities of hospital internship and residencies. The status of dental research, together with problems for investigation and current progress, are thoroughly outlined

This book will be of benefit to the dentist, the physician, and the layman who are interested in getting an authoritative view of dentistry

LAWRENCE J DUNN

Acute Injuries of the Head Their Diagnosis, Treatment, Complications, and Sequels By G F Rowbotham, B Sc (Manchester, Eng.) Second edition Octavo of 424 pages, illustrated Baltimore, Williams & Wilkins Company, 1945 Cloth, \$850

This treatise deals with the various lesions of the head that result from contact injuries of this structure. This includes scalp, skull, brain, and cranial nerves, the lesions of the brain occupying the important position in the discussion. In these considerations the patient has not been forgotten as

[Continued on page 2484]



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[Continued from page 2482]

evidenced by chapters concerning the sequelae of head injury and the rehabilitation of those so injured. The author's style makes the book very readable. The subject matter is presented in a manner quite readily comprehended even though one does not possess a detailed knowledge of neural anatomy and physiology. This book is highly recommended to all those charged with the care of patients who have sustained craniocerebral injuries

JEFFERSON BROWDER

Introduction to Surgery By Virginia Kneeland Frantz, M D, and Harold Dortic Harvey, M D Duodecimo of 216 pages, illustrated New York, Oxford University Press, 1946 Cloth, \$2.50

This short text deals with the general principles of surgical practice. The pathology of injury, inflammation, and repair is presented. Degeneration, regeneration, hypertrophy, and atrophy receive attention. Various types of wounds in the skin, bone, and the viscera, and the principles in their handling are outlined. Although the book is called an introduction to surgery, it requires considerable knowledge and experience on the part of the reader to appreciate the full value of the material.

WILLIAM SHEINFIELD

How to Live Rules for Healthful Living Based on Modern Science By Irving Fisher, Ph D, and Haven Emerson, M D Twenty-first edition Duodecimo of 354 pages, illustrated New York, Funk & Wagnalls Company, 1946 Cloth, \$2 50

This book requires little additional review. It has already been introduced to the public in 20 previous editions, and since 469,000 copies have been sold, at least that number of persons know "How to Live". And yet through the ages, rules or no rules, man continues in many millions to roam over the surface of this planet.

Indeed, many more would continue to live a longer and happier life if the information contained in this volume could be made available to all. The doctor as well as the layman can profit by a careful perusal, in fact, some of the contents are sufficiently technical to belong almost exclusively in the domain

of the doctor

S R BLATTEIS

The Peripheral Circulation in Health and Disease A Study in Clinical Science By Robert L Richards, M D Octavo of 153 pages, illustrated Baltimore, Williams & Wilkins Company, 1946 Cloth, \$600

For those who wish to learn the exact value of skin temperature measurements in the extremities of man, this short monograph is made to order. Many cases are illustrated with histories, charts, and drawings in which accurate resting and post nerve block temperatures are made and their significance discussed. Disorders included are occlusive vascular disease, "Raynaud's Phenomenon," nerve injuries, and "immersion foot syndrome." There is a brief section on the technic of measuring skin temperatures. Although this is not a monograph on therapy, the rationale of such procedures as cold therapy is discussed with sound physiologic basis.

The monograph is written in the spirit of the late Sir Thomas Lewis and frequent mention is made of his work. Those interested in this limited field will

find it well worth their study

JOSEPH R DIPALMA

The Medical Clinics of North America. Chicago Number Octavo Philadelphia, W B Saunders Company, January, 1947 Published Bimonthly (six numbers a year) Cloth, \$16 net, Paper, \$12 net

As usual, the Medical Clinics for January, 1947, cover a wide field in practical medicine Radio-active phosphorus, nitrogen mustards, antibiotics, and antihistamine substances are covered in the early chapters. Infectious diseases, including a fine review of meningities, are covered in five sections. There is an interesting review by Katz on the electrocardiogram in heart strain. This volume is well worth careful study.

ANDREW M BABEY

The Principles of Neurological Surgery By Loyal Davis, M D Third edition Octavo of 540 pages, illustrated Philadelphia, Lea & Febiger, 1946 Cloth, 87 50

This is the third edition of an orderly and well-presented discussion of the lesions of the nervous system that lend themselves to surgical therapy. The author states that the book is written for physicians and students and modestly considers it to be of no help to experienced neurologists and neurologic surgeons. We are all physicians and students, and neurologists and neurologic surgeons could profit by

a critical perusal of the 532 pages

Following a somewhat abbreviated but precise and adequate presentation of neurologic diagnoses, consideration is given to all the commonly encoun tered pathologic states of the nervous system that may be cured or favorably modified by surgical methods. The discourse on tumors is especially creditable. Congenital and traumatic lesions, as well as lesions due to various infections, are appropriately considered. The text of this edition has been brought up to date.

JEFFERSON BROWDER

Pre-Frontal Leucotomy in 1,000 Cases Board of Control, England and Wales Octavo of 31 pages, illustrated London, His Majesty's Stationery

Office, 1947 Paper, 6d

This is a 25-page report of 1,000 cases of prefrontal lobotomies performed on 1,000 seriously ill mental patients, in various county and borough hospitals in England and Wales Since Dr Monz had introduced this operation in 1935, many similar operations were performed in this country and in England "The purpose of the operation is to sever the connection between the patients' thoughts and emotions, to take the sting out of the patients' experiences and to diminish their mental tension, and thus favor improvement of the mental disorders" The object of the operation is to cut the white matter connecting the prefrontal cortex and the thalamus When the operation is successful, the dorsal medial nucleus of the thalamus degenerates In general, the most difficult, chronic, and prognostically hopeless patients were subjected to this operation The results were gratifying, and were similar to the reports published in this country The report is a good summary of the subject

IRVING J SANDS

Emergency Surgery By Hamilton Bailey, F R. CS (Eng.) Fifth Edition. Octavo of 960 pages, illustrated Baltimore, Williams & Wilkins Company, 1944 Reprinted 1946 Cloth, \$18

The author has written a comprehensive volume on the treatment of surgical emergencies The text

[Continued on page 2486]



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[Continued from page 2484]

is clear, concise, and profusely illustrated with

photographs, diagrams, and sketches

The chapters on the surgical diseases and complications of the abdomen and its contents are noteworthy Incidents in the author's surgical practice serve to illustrate methods of treatment. More recent advances in therapy make the chapters on burns, cellulitis, and carbuncles inadequate book is well written and can be recommended

RALPH WOLFE

Radical Surgery in Advanced Abdominal Cancer By Alexander Brunschwig, M D Octavo of 324 pages, illustrated Chicago, University of Chicago Press, 1947 Cloth, \$7 50

A physician who declares a patient "inoperable" often fails to realize his responsibility for a mortality higher than operation per se Brunschwig, presenting 100 cases of radical but discriminate surgery, with errors as well as triumphs, provides a basis for revaluating the term "inoperable"

This book is timely because of the recent tremendous advances in supportive therapy protein, electrolyte, and vitamin balance, chemotherapy, massive transfusions, modern anesthesiology, and operative skill. The frontier of reasonable operability has expanded

WILLIAM H FIELD

Cardiovascular Diseases By David Scherf, M D, and Linn J Boyd, M D Octavo of 478 pages, illustrated Philadelphia, J B Lippincott pages, illustrated Philade Company, 1947 Cloth, \$10

This volume is a brief presentation of cardiology and peripheral vascular diseases. Being bric covers certain important phases very sketchily Being brief, it ry sketchily To pregnancy and heart disease, for example, are allotted four pages, and to the cardiac patient who needs surgery, one page. It is useful as a ready reference or as a textbook for students

Andrew Baber

Urgent Surgery Volume I Edited by Julius L Spivack, M D Contributors, Gustavus M Blech, M D, Warren H Cole, M D, A M Doghotti, M D, et al Octavo of 714 pages, illustrated Spring-field, Illinois, Charles C Thomas, 1946 Cloth, \$10 50

This first volume is edited by Dr Spivack, whose contributions to surgery are many and well known. The emergent preoperative, operative, and post-operative treatments are explained in detail Diagnosis is discussed with illustrative cases, in some to further emphasize the individual instances, methods of handling various emergent problems

It should be noted that this volume deals almost entirely with emergent surgery of the abdomen, and is an excellent work for the intern, resident, and

general surgeon

HERBERT T WIKLE

Tutoring as Therapy By Grace Arthur, Ph D Octavo of 125 pages, New York, Commonwealth Fund, 1946 Cloth, S1 50

As the name of the book indicates, the author, a psychologist, describes the factors necessary for successful use of tutoring as therapy She refers to experiments with children in the first grade of school to indicate the necessity of private instruction for some, even though of normal mentality There may be a special disability, prolonged illness, or specific emotional problem which prevents the success of an individual child to learn in a group There are chapters on selection, training, and supervision of tutors, methods used in remedial teaching, and tutoring as therapy and as a community project

STANLEY S LAMM

Parenteral Alimentation in Surgery With Special Reference to Proteins and Amino Acids By Robert Elman, M D Octavo of 284 pages, illus-trated New York, Paul B Hoeber, Inc., 1947 Cloth, \$4 50

Great improvement in parenteral alimentation in surgery has taken place in recent years geons of today emphasize with justice the importance of the support which thus therapy lends to the welfare

of the patient

Dr Elman has covered the entire subject, beginning with the history of parenteral feeding, outlining the indications and elaborating on the need for water, electrolytes, vitamins, fats, carbohydrates, and proteins The author has presented in orderly manner all the useful factors involved in modern parenteral feeding. While some might claim that he has overstressed the value of the amino acids, this has in no way detracted from the usefulness of a The author deserves consplendid monograph gratulations, and the book should find a place in the library of every student of surgery

ROBERT F BARBER

Conduction Anesthesia Clinical Studies of George P Pitkin, M D Edited by James L Southworth, M D, and Robert A Hingson, M D With chap-ters prepared by Winifred Pitkin, M D, A. R. McIntire, M D, Frederick M Allen, M D, d al Illustrations prepared under the direction of Dr George P Pitkin Quarto of 981 pages, illustrated Philadelphia, J B Lippincott Company, 1946 Cloth, \$18

This excellent volume is the answer to all questions concerning new and old procedures in original

anesthesia

There has been a long-felt want for a book of this The sections on thoracic, sympathetic, lumbar, and sacral blocks are excellent The section on spinal anesthesia, although well done, could be more modern One detracting quality of the book is the poor location of the illustrations in regard to text, i.e., often there is a variation of five and six pages between the text and the accompanying illustration The illustrations are profuse, original, and clearly

This large volume has much to recommend it and should find wide use

F PAUL ANSBRO

A Textbook of Clinical Neurology By J M Nielsen, M D Second edition Quarto of 699 pages, illustrated New York, Paul B Hoeber, Inc., 1946 Cloth, \$7.50

This edition, despite the claims of the publisher, shows relatively little change as compared with the previous one. The author's presentation is refreshing in its chatty and informal style and makes easy reading. At times it is too discursive. The student who looks for a systematic and thorough account of a subject will not always find it here This book does not lend itself to teaching. It serves as an additional treatise which is useful because it is personal, and sometimes one runs across material not found in other texts.

The illustrations are clear and frequently good An excellent 10b is done of the makeup, the book is attractive and readable. The chapters have useful

[Continued on page 2488]

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[Continued from page 2486]

bibliographies but the render is sometimes annoyed to find reference in the text to papers which do not appear in the bibliography. The proofreading has not been adequate. Some errors in punctuation noted in the first edition are still present in this one. The index in this edition has not been corrected for changes in paging. And to mention only one more shortcoming, the pinealoma is not even mentioned in the discussion of brain tumors.

I S FREIMAN

Five Million Patients The Professional Life of a Health Officer By Allen Weir Freeman, M D Octavo of 299 pages New York, Charles Scribner's Sons, 1946 Cloth, \$3 00

Five Million Patients is the biography of a physician as a medical student in a prominent medical school, as an intern in a large city hospital, a few years of private practice, then in the field of public health as a local, a state, and a Federal governmental officer, and at last reaching that goal of many physicians, an instructor and, finally, a professor at his alma mater

The title is rather misleading, as it would imply a private practice in which there was a personal contact with all these patients, whereas it deals with groups encountered in the activities of a physician carrying on medical and executive work in the field of public health. Physicians as well as the general

public will enjoy reading this book

C T GRAHAM-ROGERS

Concise Chemical and Technical Dictionary Edited by H Bennett Octavo of 1,055 pages Brooklyn, Chemical Publishing Company, 1947 Cloth, \$10

This book of over 1,000 pages contains about 50,000 definitions covering many fields of scientific and technical advances. There are numerous trade names and proprietaries, especially in the field of plastics. It appears to be a complete and handy reference book.

ANDREW BABEY

Uterine Contractility in Pregnancy A Study of the Contractions of Pregnancy and Labor Under Normal and Experimental Conditions By Douglas P Murphy, M D Octavo of 134 pages, illustrated Philadelphia, J B Lippincott Company, 1947 Cloth, \$500

The obstetric specialist will read this little book with great interest. It is a report of observations and conclusions of the author, in about 1,200 cases, in external hysterography of the pregnant uterus with use of the Lorand tocograph. Primary mertia is so important, and so little is known about, it that the reader will be stimulated. The discussion of morphine and pituitrin is of interest. The tocograph is said to measure the hardness of the uterine muscle, though this is debatable.

CHARLES A GORDON

Foods Their Values and Management. By Henry C Sherman Octavo of 221 pages New York, Columbia University Press, 1946 Cloth, \$3 25

In this work the author is much influenced by reports of United Nations Food and Agriculture Organizations, the Committee of Nutrition and Food Management, the United States Department of Agriculture, and the National Nutritional conference held in Washington, in May, 1941 He dis-

cusses food economics on a broad scale, food availabilities, and the contents of food essentials

It is a good book for lay information. For therapeutic references the physician can find better sources

MORRIS ANT

Hygiene A Textbook for College Students on Physical and Mental Health from Personal and Public Aspects By Florence L Meredith, M D Fourth edition Octavo of 838 pages, illustrated Philadelphia, Blakiston Company, 1946 Cloth \$4

Hygiene is covered by the author as it affects the individual and groups, the objects that arise from them, and what action is scientifically appropriate on the part of the layman, especially the college student. There is a vast amount of historic, factual, and scientific data which makes the contents in teresting as well as educational.

It is well illustrated and brings up to date the multiple contributions to hygiene for the public health officer and worker, and is especially invaluable to the student because of the thorough and comprehensive manner in which the subject is covered. It contains a splendid bibliography for

reference and is well indexed.

A JABLONB

Functional Cardiovascular Disease By Lt Col Meyer Friedman, USMR Octavo of 266 pages Baltimore, Williams & Wilkins Company, 1947 Cloth, \$3 00

The author chooses the title Functional Cardiovascular Disease for the syndrome previously described by different authors under such titles as "neurocirculatory asthenia," "the irritable heart," "the soldier's heart," and "effort syndrome". He presents several interesting original clinical observations to show that the condition is probably due fundamentally to cortico-hypthalamic imbalance with hypothalamic dysfunction and "cortical recession". This reviewer agrees with the hypothesis and believes, therefore, that a title such as Neurogenic Cardiovascular Disturbances would be more appropriate for the monograph. The complete review and discussion of the available literature by the author are very valuable. There is, however, considerable repetition of the subject matter in the various chapters, which leads to some confusion. In general, the monograph is a valuable contribution.

Your Rheumatism and Backaches By Joseph D Wassersug, M D Duodeeumo of 310 pages New York, Wilfred Funk, 1947 Cloth, \$2 50

In the present age of scientific reporting and exact measurement, the paternal, pleasant, and only mildly informative book is dubbed "lay" reading. To popularize an organized interpretation of a difficult subject in a comprehensive, simple, and informative manner should be the aim of the writer for the nonprofessional group. Too often the public is given "anything" in place of "something." The theory is that since no professional reader will criticize, an accurate evaluation of the field is unnecessary.

Rather than this book, the public needs a critical interpretation of the field of "rheumatism". As a hook to persuade people to go to the doctor to have blood tests, x-rays, etc., it may well serve a purpose

HENRY M FEINBLATT

[Continued on page 2490]

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Neurosis and the Mental Health Services ByC P Blacker, M D Octavo of 218 pages New York, Oxford University Press, 1946 Cloth, \$5 00 New

This book deals with the results of a survey of the psychiatric outpatient facilities of England and of Wales, and is based upon the returns of a questionnaire which asked for figures for the years 1938, 1940, 1941, and 1942 The immediate purpose of the survey was to bring about a better coordination and distribution of the country's psychiatric facilities which had been depleted by the needs of the fighting The ulterior purpose was to effect an integration of the psychiatric resources into the general health service of the nation

It offers a plan for an "ideal" setup for the care of the psychiatric, outpatient, people in a population of one million. The book will be found helpful to all psychiatrists and especially to those who deal with the administrative aspects of the care of the

psychiatrically sick

IRVING J SANDS

The Eye Manifestations of Internal Diseases By S Tassman, M D Second Edition St Louis, C V Mosby Company, 1946 Cloth, \$10

The second edition of "The Eye Manifestations of Internal Diseases" by I S Tassman, so soon after the appearance of the first edition, is very good evidence that the book has been of decided value to the medical profession He has added descriptions of numerous diseases and a number of new illustra-One of the characteristics of the war years has been the presentation of such entities as Hurler's disease, Bowen's disease of the cornea, toxoplas-

mosis, etc
Dr Tassman acknowledges the many sources from which he has drawn material and illustrations for

the book

JOHN N EVANS

The Crusade Against The Challenge of Polio Infantile Paralysis By Roland H Berg Octavo of 208 pages New York, Dial Press, 1946 Cloth,

This little book is rightly titled. Polio is still a challenge, here we are told much of what has—and, more truly, has not—been accomplished in the fundamental prevention and cure of this very serious It also reports progress in treatment and is fair to those who have offered "specifics" which failed and to those presenting treatments of symptomatic value

Berg in his personal "note" says Yet Dr "Nothing that medical science can do can prevent one case or one epidemic from occurring" And Mr O'Connor in his introduction quotes "No preven-O'Connor in his introduction quotes tive, no cure "

The challenge must be met

W D LUDLUM, Sr

Intracranial Arterial Aneurysms By Walter E Octavo of 147 pages, illustrated Ithaca. Cornell University Press, 1944 Cloth \$2 50

This is a 147-page monograph, well-illustrated and appended charts, based on a study of 108 patients with 133 aneurysms, all verified by either necropsy or operation Many new facts have been presented, particularly with reference to the therapeutic approach Essential details are recorded relative to surgical procedures designed to cure these lesions Certainly the author made great studies in this un-explored field of surgical endeavor This book should

serve as a great stimulus for well-trained and enterprising neurosurgeons In addition, it is an excellent account of the variations in the arteries supplying the brain and the locations of the ancurysms arising therefrom

JEFFERSON BROWDER

Demonstrations of Physical Signs in Clinical Surgery By Hamilton Bailey, FRCS (Eng.) Baltı edition Octavo of 375 pages, illustrated more, Williams & Wilkins Company, 1946

The text starts with a discussion of basic physical Swellings, fluctuation, edema, translumination, and other phenomena are demonstrated. In flammations, ulcors, and sinus tracts are pictured, the more common clinical conditions being shown

The chapters then are arranged on a regional basis, the mouth, face, neck, head, extremities, abdomen, chest, etc., being considered in turn Im portant findings and methods of cliciting these are given. The general principles of physical diagnosis are stressed In addition many illustrations of specific diseases are shown. The text is also a fine compilation of the most common syndromes or diseases encountered by the general surgeon.

WILLIAM SHEINFELD

By Joseph Earle Moore, Penicillin in Syphilis M D Octavo of 319 pages, illustrated. Sprinfield, Ill, Charles C Thomas, 1946 Cloth, \$5.00

This informative monograph on penicillin in syphilis is intended to supplement the author's larger and earlier volume, The Modern Treatment of Syphilis

Penicillin dosage schedules for syphilis are analyzed in terms of successes and treatment failures. The various toxic manifestations are explained in detail with special reference to the Jarisch-Hercheimer reaction The interpretation of serologic tests in patients previously treated with penicillin for purposes other than syphilis and the evaluation of serologic reversibility following therapy are both discussed in an enlightening manner

The bibliography and author index are complete. The book is actually a pooled, cooperative undertaking of 44 groups and clinics in the United States, including the Army, Navy, and Public Health centers, and should be most useful to venereologists

and dermatologists

LEO LOEWE

Technique of Psychoanalytic Therapy By Sandor Lorand, M D Octavo of 251 pages New York, International Universities Press, 1946 Cloth,

Dr Lorand is an experienced and popular teacher, lecturer, and practitioner of psychoanalysis He has published several books and numerous articles dealing with the subject This book is based upon the material for a course for psychiatrists who are students in the last year of analytic training It covers the entire subject of psychoanalytic therap) from the first interview with the patient to the termination of the analysis It contains numerous hints and suggestions as well as some positive instructions in the methods of dealing with different patients and with the problems that arise during the It is a useful book which will find course of therapy a warm welcome by all who are interested in the subject It is highly recommended.

IRVING J SANDS

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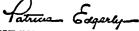
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 Size of Articles.—It is earnestly desired that - scientific articles shall not exceed 6 Journal pages at the outside Longer articles tend to lower reader interest. An average of five or six seems to be the most desirable from this point of view Calculation can readily be made by multiplying the number of double-spaced typewritten manuscript pages by the fraction two-fifths, e.g., twelve manuscript pages will make five Journal pages

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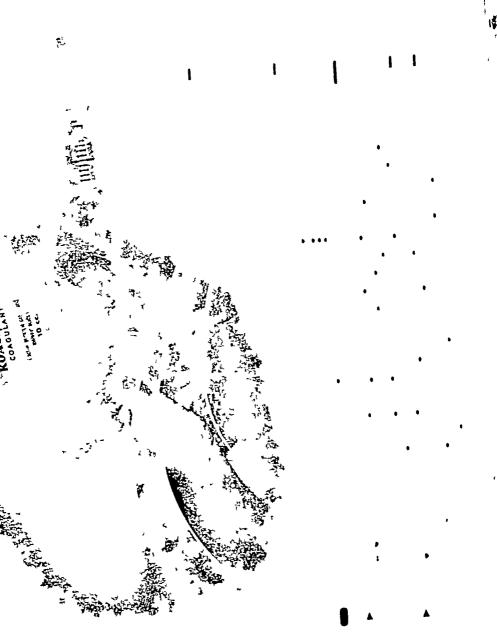
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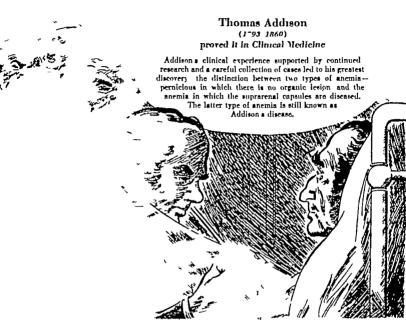
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**VOLUME 47** 

DECEMBER 1, 1947

NUMBER 2:

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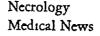
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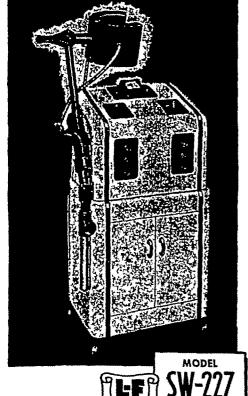
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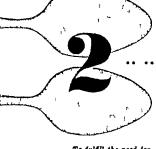
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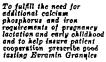
















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## Octin - for Relief of Smooth Muscle Spasm

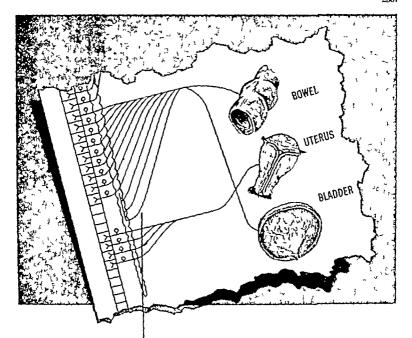
Octin is an antispasmodic, indicated for the treatment of spastic conditions, particularly of the genito-urinary and gastrointestinal tracts

TABLETS - 2 grains Octin mucate
ORAL SOLUTION - 10% aqueous solution (1½ grains per cc.)
AMPULES - 1 cc (1½ grains Octin hydrochloride)

Octin (methyllsooctenylamins) Trade Mark Blibuber

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when pain is caused by spasm

In smooth muscle spasm—gastrointestinal spastic states, primary dysmenorrhea bladder spasm—whether of neural or muscular origin relief may be obtained with the effective synthetic antispasmodic, Payatrine

#### PAVATRINE

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- † Saligenin is ortholy droxy benzy lalcohol H W & D

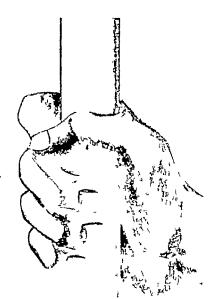


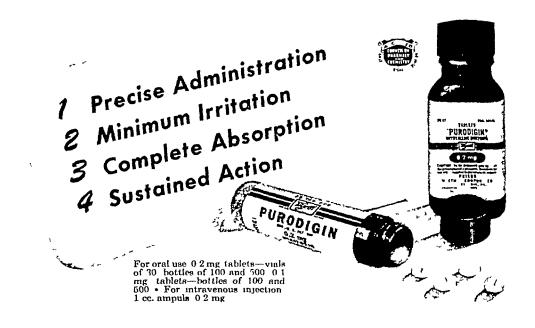
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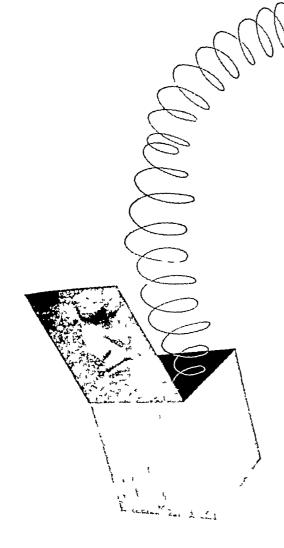
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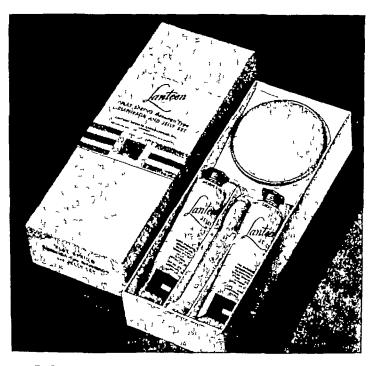
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\* Meakins, J C The Practice of Medicine, The C V Mosby Company, St Louis, 1940, p 729

\*\* Patek, A. J The Evaluation of Dietary Factors in Treatment of Laennec's Cirrhosis of the Liver, J Mount Sinai Hospital, 14 1, 1947



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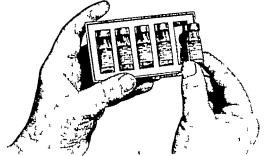
\* Laryngoscope, Feb 1935, Vol XLV, No 2, 149 154 Laryngoscope, Jan 1937, Vol XLVII, No 1, 58 60



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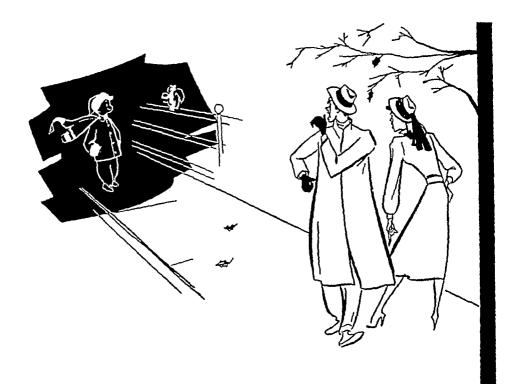
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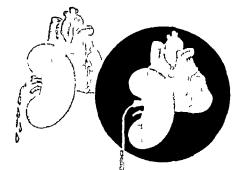
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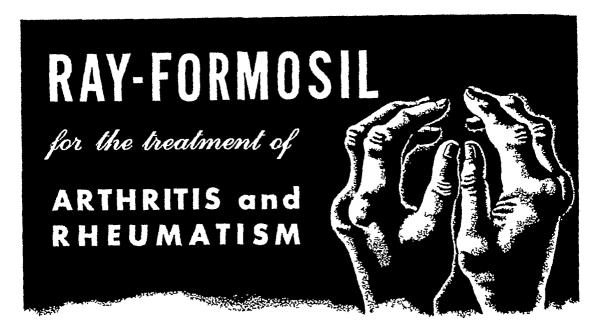
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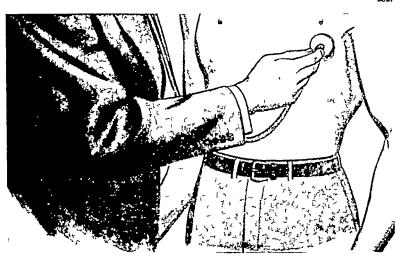
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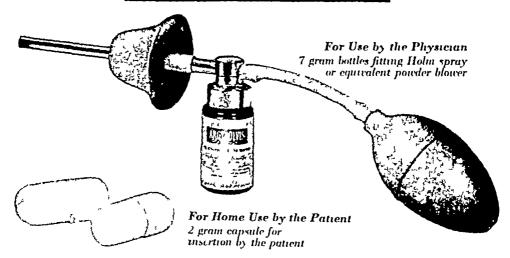


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\*Reich Button and Nechtoic Treatment of Trichomonas Vaginalis Vaginitis Surgery Cynecology and Obstetrics May 1947,pp 891-896

# **NEW YORK STATE JOURNAL OF MEDICINE**

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VOLUME 47

DECEMBER 1 1947

DWIGHT ANDERSON LAURANCE D REDWAY MLD JAMES R. REULING M.D.

NUMBER 23

### Editorials

#### Dr Louis Bauer Tells the Facts

At a time when it is sorely needed, a straightforward, factual, and well written book, Private Enterprise or Government in Medicine, by Louis Hopewell Bauer, A.B., M.D. F.A C.P. comes from the press of Charles C Thomas, Springfield, Illinois. Dr Bauer, a Trustee of the American Medical Association, President of the Medical Society of the State of New York, Diplomate of the American Board of Internal Medicine, writes from an exceptionally well-informed background of long service to organized medicine and an intimate knowledge of his subject.

Clearly and concisely he presents the facts which should be the tools for intelligent argument, rational debate, and constructive thinking as to whether private enterprise shall continue to exist in medicine or be entirely replaced by government agencies The background of the problem is discussed, then the deficiencies of our present system of medical care are frankly stated

Next, the facts concerning the present health conditions in the United States are Selective Service statistics and their real or nonpolitical significance to the health of the nation

dealt with, and the distribution of physicians and hospitals, care of the indigent, the

Other chapters deal factually with foreign medical systems, compulsory sickness insurance in the United States, the development here of voluntary insurance systems, the programs of the American Medical Associa tion, and recent proposed legislation such as the Fulbright-Taft Bill (S 140 of 1947) and the Taft-Smith Ball Donnell Bill of 1947

Here is a most useful handbook with an extensive bibliography, clearly expressed and covering the entire field of controversy between the advocates of private enterprise in medicine and those who support compulsory sickness insurance

As Dr Bauer says in his preface "Propaganda has poured forth in an unremitting The subject which should be con fined to the field of medical economics, has become a political football. The public. which, eventually, must decide the question has not been given all the facts. The public wants to know both sides of the question '

Recent evidence in House Report No 786, referring to the so-called "health workshops," seems to show the use of government funds in an improper manner for propaganda activities supporting compulsory national health insurance. It would appear that "a key group on the govern-

used the workshop method ment payroll, of discussion subtly to generate public sentiment in behalf of socialized medicine" Within certain agencies of government, Dr Bauer notes, for example, there were prepared, according to the House Report noted above, certain "pamphlets and propaganda literature for the CIO, the AFL, and the Physicians' Forum, much of which material supported socialized medicine in every approach and dismissed contemptuously all arguments controverting the fixed position of the Social Security Board" Dr Bauer adds this recent material as an example of some of the propaganda devices which have been employed to generate public sentiment favorable to socialized medicine

The book is dedicated to Dr Nathan B Van Etten, former President of the American Medical Association and to Dr Olin West, for twenty-five years Secretary and in 1946-1947 President-Elect of the American Medical Association It should be in the hands of every doctor of medicine, for contained in it are the answers to nearly all the questions anyone might ask relative to the subject

Dr Bauer is to be heartily congratulated on a most necessary contribution to the eventual solution of a knotty problem in the evolution of medical service for the people of the United States

As he rightly says "The social order of the country has changed One group is still fighting the change and would hold to the status quo ante in medicine. Whether or not we like the new social order, it is here and must be faced. Ultra conservatism will get us exactly nowhere. Neither extreme will solve the problem of a better distribution of medical care."

### True Ability Versus Labels

Are the sands of America's independent judgment running out? Is this true in the medical profession?

The outstanding characteristic of the profession used to be the acceptance of personal responsibility. The old family doctor made his own judgments and his own mistakes and stood by them on his own two feet. He stood or fell by the opinion of his peers—by the reputation that he enjoyed in his own community. He was an individualist

Contrast his attitude with that of a brilliant young man in his sixth year of residencies at various hospitals. When asked when he was going to emerge from his monastery and face the world, he said "Yes, I suppose it's time I did. But then it's such a pleasant life. You have great responsibilities, but if you really get into a jam, you just call one of the Attendings in consultation"

Even that attitude is not the worst of it Nobody seems to feel capable of standing on his own reputation. Those in positions of authority do not trust their own judgment Everyone has to be labelled. The doctor now has to have not only his degree from his medical school and his license from the state to practice, he has to have diplomas from far-distant, impersonal boards, beginning with the American College of Surgeons and going on from there to the necessity of being a diplomate of some specialty board

Suppose now he merely desires to care for sick people, to practice medicine. He doesn't care to be a specialist, just to remain a general practitioner. Well, from now on even to do that he must be a diplomate of the Board of General Practitioners or the like

Labels! And more labels! A correspondent tells us of a brilliant girl who had taken the Stevens' Institute aptitude tests. She had been passed in art, creative ability, exceptional aptitude in two foreign languages. She was rejected as a job applicant by two of our most fashionable magazines. Why? Because she had no college degree.

No one dares accept anyone on his own opinion of the other's merits. Everyone previously must have been passed on by someone or something else. Costume designers and editors of fashion magazines are rarely conformist types likely to be the holders of college degrees. But personnel managers can refuse to hire potential geniuses because they are not labelled with the tag of collegiate approval. If one of

their choices turns out to be a failure the blame is not theirs "She had a degree from Wahoo College, didn't she?"

A candidate for medical school is accepted because he has a brilliant premedical scholastic record. Is there anything in that which determines his qualifications to be a good doctor? Those who got their knowledge out of books may be notably deficient in their knowledge of and ability to get on with other human beings.

A surgeon of our acquaintance this morning got a communication from the American College of Surgeons asking him to recommend candidates for the Credentials Committee of this State "Inasmuch as the personnel is

secret to all except the Committee and the College Office ," read the letter, in part

We know of no organization except the Ku Klux Klan and others of that ilk which keeps the names of its Admissions Committee secret. Why should it? Can we not even know the names of those who pass upon qualifications of our future surgeons? Under such circumstances how are we to know whether the will of the majority is respected? Ever hear of the Iron Curtain?

Are we finally to abandon the judgment of our peers, the people with whom we were brought up, who know us for what we are, who live with us, and upon the persons of whose families we practice?

#### The Choice is Yours

Does the ordinary practitioner of medicine understand or practice psychosomatic medicine?

In the old days, the well fed philosophers of the Athenian democracy used to loll about the Agora asking which camefirst, the chicken or the egg, or, did Adam have an umbilicus? The conundrums today survive in terms of psychosomatic medicine paraphrased as "have you a gastine uleer because you really have one, and, because you have one, does its containal gnawing pain make you snappish with your wife? Or don't you like your wife very much, and does your containal suppressed desire to snap at her give you a gastine uleer?"

Peter J Steinchron, M.D., 1 m his book What You Can Do for High Blood Pressure, says 1 "The doctor interested in preventive medicine tells the patient whose pressure is 160 to live like the patient whose pressure is 200. There is no difference. In both cases the treatment is the same. We outline a new way of life. This consists of relief of inner tension, relief from strain of business and social life, sufficient rest and relaxation, numerous vacations, the cutting down of aggressiveness and ambition, and any of the other methods we use to influence the patient to live along at thirty miles an hour instead of the usual sixty."

Doubleday and Company New York, 1947
 New York Times Book Review Section September 7

We are 100 per cent in agreement with Dr Steinchron in principle. His advice is admirable—It outlines perfectly the way of life that probably every harnssed doctor has been searching for over since he started practice.

His remarks point up beautifully one of the most senious fallaces of the present relations between the public and the medical profession.

How is the patient to achieve the balanced life that the doctor so sensibly advises? The doctor's advice is perfect The only trouble with it is that the patient can't take it. Incidentally, is the doctor who prescribes such sweeping changes in the patient's character acting a little too much like God? How does he know what is best for a man? Perhaps his drive and his ambition do give him ulcers. Perhaps his inferiority complex does goad him on to efforts which bring on high blood pressure We concede that. But are there not sufferers who would prefer to die from headaches and high blood pressure, who would honestly rather die mil honaires in their early fifties than live placidly to ninety in the vegetable existence prescribed by their medical consultant?

We think that the public and the medical profession are walking a perilous tightrope between two extremes. On the one hand, we have the patients, such as those who take refuge in psychoanalysis, who wish to throw

themselves body and soul upon the bosom of the doctor

On the other hand, we have the doctor possessed of such superb self-confidence that he has no hesitation in presuming to dictate to the patient the ultimate and most intimate details of his private life, in order, forsooth, that the patient may live a few years longer A few years longer? What for? May it not be true for some that "One crowded hour of glorious life is worth an age without a name?"

The dilemma we have outlined betokens a serious weakness of the present generation. We shun any political implications that might be read into an editorial in a medical journal, but is it not true that the world to-day is broadly divided into two classes?

Those who want to be told what to do and those who want to tell others what to do?

When we go to a doctor we would like him to give us the most searching physical and mental examination possible. He would neglect no nook or cranny of our psyche or our soma. When he finished he would lay his findings on the table as dispassionately as one would set out a set of chessmen.

He then would say, "This is what I think Take the findings home with you. Think them over. Come to your own conclusion Live a long life according to my prescription, or a short one according to your preference. The responsibility for your choice is not mine. It is your life.

"Lave it, understanding that the choice is yours"

#### Universal Medical Service

Under the above title the Canadian Medical Association Journal1 discusses editorially a pamphlet by Dr Douglas Robb, MD, Ch M, FRCS (Eng), FRACS, entitled "Health Reform in New Zealand" "Of all the democratic countries," says the CM.AJ, "New Zealand has gone furthest in trying to work out a scheme of social security which includes the provision of medical service for the entire population" The plan for public organization of medical services\* under the Social Security Bill was undertaken by the first Labour Government in November, 1935 The Bill was passed in So New Zealand has had five years' experience of such a scheme

The Act contemplates first, replacement of existing noncontributory civil pensions by a system of monetary benefits on a contributing basis, and second, a system of general practitioner service available to all, with maternity, pharmaceutic, and hospital benefits, x-ray, laboratory, physiotherapy, neurosurgery, district nursing, and domestic service to be added later

"Apparently," says the CM A.J, "the Government worked out its scheme without consultation with organized medicine in the form of the New Zealand Branch of the British Medical Association The Gov-

1 47 65 (July) 1947

• Italies ours, Ed Apparently a new phrase to avoid the socialized medicine label

ernment measure was political in conception and its contents were not made known to the B M.A until its introduction into the House "

To all intents and purposes, comments the CMAJ, the government is faced with an unlimited liability Dr Robb says, "The fund has to be a bottomless pit" New Zealand seems to be committed to this policy of universal free (so-called) medical service

Turn now to House Report No 786, 80th Congress, 1st Session, July 2, 1947, page 6, of the Committee on Expenditures in the Executive Departments Says the report, "Certain documentary evidence has come to the attention of your committee, that the Bureau of Research and Statistics in the Social Security Board also maintains close contact with movements for compulsory health insurance in other countries

"Under date of May 14, 1947, Mr Isadore Falk, Director of the Bureau of Research and Statistics, sent a memorandum to the Acting Commissioner for Social Security, urging that one Jacob Fisher, a member of Mr Falk's staff, be sent to New Zealand, at Government expense, to study compulsory health-insurance programs and activities in that nation "

Well, what is wrong about that? Shouldn't the Bureau of Research and Statistics

study New Zealand's Labor Government system of socialized medicine or, if you will, its public organization of medical services Mr Falk, who proposed to send Mr Fisher to New Zealand, has been much interested in the Wagner-Murray-Dingell bills of recent years, if our information is correct

His choice of a vessel "to study compulsory health insurance programs and activities" in New Zealand at U.S. Government expense in the person of one Jacob Fisher shows what is wrong. Mr. Fisher, it appears has been documented by the House Committee on Un-American Activities for "almost uninterrupted association, since 1939, with

<sup>3</sup> House Report No. 786 p 7

various Communist-front and fellow-traveler organizations in the United States. At various times, according to his record, Jacob Fisher has been identified with seven different groups or organizations avowedly sponsoring the Moscow party line in the United States "2"

With a record of the sort detailed above, what is Mr Jacob Fisher doing on the staff of Mr Isadore Falk, Director of the Bureau of Research and Statistics in the Social Security Board of the United States Government? Interesting, isn't it? When you think about it As you surely must one of these days or take the consequences and like it.

#### Doctors and Money

We see by the papers, the Saturday Evening Post¹ in this instance, that there is a town with no unpaid bills "Hyannis," says the article, "is a credit town, with no unpaid bills except those of the doctor, who loses 20 per cent Tho general store has had no loss in twenty years "

Hyannis, incidentally, is in the sovereign state of Nebraska, one of those Western states which we in our innocence had always pictured as peopled by great-hearted, rugged, honest characters whose greatest pride was to be beholden to no man. You know, the Village Blacksmith type Well—just another illusion shattered "no unpaid bills except those of the doctor, who loses 20 per cent." The article says just that. No why or how Apparently just a local custom. The inference keep a general store—in Hyannis.

But the article does bring doctors and money together in print. This seems encouraging. Doctors seldom face squarely the problem of money in their professional life. They might well face it now. Seems as though they'd have to, if they want to go on living. Take the case of M. Moreau de St. Méry for example ? He was a noh Creole aristocrat, was educated in France as a lawabiding Liberal in the days before the Terror,

and escaped the country twelve hours ahead of the guillotine. He was the Kerensky of a hundred and fifty-five years ago. He came to this country, and he kept a diary, which we recommend to any of our readers who would find interesting the life of a man catapulted from "king of Paris for three days" to that of a shipping clerk in a Philadelphia warehouse

M Moreau de St Méry kept a diary as noted above and the items that appear in it most constantly are the prices of things. As an aristocrat in Trance he doubtless had never had to trouble himself about such vulgar trifles. As a proletarian, he very shortly found them matters of overwhelming importance.

Well, we know of few doctors who start life as nch anstocrats, or finish it as shipping clerks, but the prices of things have to be considered, nevertheless by doctors as well as anyone else

We have heard complaints recently that the fees for Workmen's Compensation cases were, in spite of their rocent revision upward, still ridiculously low. In the course of an argument on the subject we heard a doctor, supposedly well acquainted with the attitude of state legislators, and, consequently, we suppose, of the public, say "For Heaven's sake, don't put yourselves on record as wanting to make any more money for the doctors. The people now think of them as making more money than they ever did before, of

<sup>&</sup>lt;sup>1</sup> Saturday Evening Post 219: 112 (June 14) 1047 <sup>2</sup> de St. Méry Morsau: American Journey 1793-1798. New York, Doubleday Doran and Co., Inc., 1947 pp. 187-

taking vacations, of going on fishing trips, of never being at home when they are wanted "

To some, this attitude of the people may seem to be a recent one, but Max Neuberger in his *History of Medicine* quotes Galen

"Between robbers and physicians is this difference only, that the former's misdeeds are done in the mountains, the latter's in Rome"

We think that the relations between the public and the medical profession would be enormously bettered if both parties to a private—as well as to a public—medical contract would talk over their arrangement before they entered into it A young man, for instance, with a congenitally weak back should surely be required to pay as much for a permanently strong one as he would have to pay for a second-hand automobile In a great majority of cases he acquires the automobile as a matter of course, but in many instances he does not want to pay for the permanently strong back We don't expect that in the case of emergency operations the cost of preserving a patient's life can be discussed But ordinarily is there a surgeon in this State who has not had the experience of being told that no expense should be spared? No expense is spared—in the matter of special nurses, private rooms, flowers, bedspreads, or what have you Until the doctor's bill comes in

If the relations between the public and its friends the doctors are to improve—as they must—we advise both parties to the medical contract they enter into to be a little more frank with each other

If they do so, we are hopeful that the doctors will not be reproached because, like every other class of men, they take vacations, they go on fishing trips, and never seem to be at home when they are wanted We still like to believe that a man's home is his castle

The doctor is the only man who can be hailed out of his at the whim of anyone who chooses to call him forth. And we are sure that he is the only member of a profession who almost invariably allows himself to be so hailed forth and for doing so is the only member of any occupation in Hyannis, Nebraska, "an honest credit town," assured of collecting 20 per cent less than what he has honestly estimated as the amount due him

Irrespective of what the future may hold in the shape of socialized medicine, of such spineless schemes to take responsibility from the shoulders of individuals, we think the public and the medical profession would both be a great deal better off if they became more practical about that horrid subject—Money They both have to live

#### Current Editorial Comment

Oxygen Poisoning Life-sustaining oxygen, when inhaled at high pressures, may cause convulsions and fatal poisoning Probably all gases are poisonous if breathed at sufficiently high pressures 1 solids and liquids are not poisonous, for the good reason that the blood does not dissolve them in toxic quantities The amount of gas taken up is in proportion to its partial Behnke and his colleagues made pressure the remarkable discovery that not only nitrogen but argon is a mild narcotic at high pressures Per weight absorbed, nitrogen and argon are just about as narcotic as Nitrous oxide and ether are nitrous oxide more efficient as anesthetics because they are more soluble, both in water and in lipoids, and for no other reason Hydrogen and belium are not appreciably narcotic at

\*Donald Kenneth W Brit Med J (May 24) 1947 pp 712-717

That oxygen is a convulsant when breathed at high pressures has been known since Paul Bert's work in 1878, but up to 1941 only about a dozen separate exposures, in which acute toxic symptoms had occurred, had been described Thework carried out by the Admiralty Experimental Diving Unit during 1942 to 1944 is described by Dr Kenneth W Donald in his article "Oxygen Poisoning in Man" This supplies quantitative data on an extensive scale concerning the effects of high-pressure oxygen, both in compressed air and under water, on large numbers of men, and with repeated experiments on the same individual The most important conclusions

ten atmospheres pressure They may well be so at fifty or a hundred atmospheres

<sup>1</sup> Editorial Brit Med J (May 24) 1947 pp 727-728

reached were (1) the extreme variability of tolerance, both between individuals and in the same man from day to day, and (2) the far lower tolerance under water than in compressed air Convulsions have occurred

at a depth of only 40 feet While breathing pure oxygen in compressed air, men present the following signs and symptoms of poisoning pallor, fasciculation of the lips and face, facial perspiration from fine beads to literal pouring, salivation, and the appearance of being under stress These are all early signs. The next group of symptoms are transient minor crises nausca, vertigo, malaise, apprehension, choking sensations, intermittent lip-twitching, rapid breathing and palpitation After a few seconds or minutes, the subject may continue symptomless for a considerable time before an acute end-point Finally the subject presents a group of symptoms signifying more intense intoxication and approach of the danger of convulsion They include depression or euphoria, irrational apprehension even to the point of acute terror, "faraway" feeling, complete indifference, somnolence, clumsiness, fidgeting, bad judgment, depression or constriction in the epigastrium or precordium, and, later, visual or auditory hallucinations signaling the approach of the end point Definite twitching of the lips usually means the endpoint is near This is the most common termination Some cases show respiratory abnormalities such as rapid panting, labored inspiration, grunting, and increasing distress to an acute state of apnea

The clinical impression was of many different patterns of two distinct processes (1) insidious intoxication of the central nervous sytem, and (2) convulsant tendency beginning usually in the muscles of the face On a few occasions, the type of the attack was syncopal The convulsive attacks of oxygen poisoning have an average duration of two minutes, the man being unconscious If returned to air at once, he had but one convulsion case, madvertent continuation of oxygen resulted in a second convulsion in thirty seconds Detailed description of these attacks is unnecessary since in all respects they resemble the major convulsive seizure of idiopathic epilepsy At no time was any attack akin to petit mal observed either clinically or electrically In oxygen poison ing petit mal is unknown

In a series of 388 dives to end point under

water, the following symptoms were recorded twitching of lips 60 6 per cent, convulsions 9 2 per cent, vertigo 8 8 per cent, nausca 8 3 per cent, respiratory disturbances 3 8 per cent, twitching of parts other than the lips 3 2 per cent, abnormal sensations of drowsiness numbness, and confusion 3 2 per cent, visual disturbances 1 per cent, acoustic hallucinations 0 6 per cent, and parasthesias 04 per cent In a senes of wet dives to toxic depths with hard work, symptoms were as follows in 120 endpoint examinations lip-twitching 50 per cent, vertigo 20 8 per cent, nausea 17 5 per cent, convulsions 6 8 per cent, choking sensations 25 per cent, dyspnea 25 per cent, and body tremors 17 per cent appears that nausca and vertigo increase in frequency if the subject is exercising Under-water divers are more free of symptoms than those in the "dry" right up to the moment of hp-twitching or convulsing This makes oxygen-breathing under water at toxic depths highly dangerous

In over a thousand experiments where subjects were breathing oxygen at toxic pressure, in not a single case has there been any positive findings suggestive of lung damage In some cases the pulse is slowed, at 90 feet, the blood pressure (systolic and diastolic) stabilizes after about twenty minutes at 15 mm above normal levels Just before the onset of acute symptoms, the blood pressure goes up another 15 to 20 There was no instance of enlargement of the heart In experiments continued over a period of three years, no adverse after-effects have been noted in any subject's neurologic integrity, intellectual ability, or personality Those who con vulsed showed electroencephalographic findings during and after the fit which were indistinguishable from that seen in grand

mal epilepsy

The most important aspect of oxygen poisoning is the intoxication of the central nervous system including the whole cerebrospinal axis and even to the most peripheral components Dickens believes the primary effect of oxygen poisoning is due to the minute impairment of brain tissue respiration, resulting from the inhibition of The secondary effects piruvic oxidase would be general poisoning of carbohydrate oxidation, since all known paths of carbohydrate oxidation converge at the stage of pyruvate In spite of the careful work of Dickens, the cause of oxygen convulsions is obscure The first requisite for its elucida

tion will be the measurement of the partial pressure of oxygen in the venous blood leaving the brain just before a convulsion If found to be several atmospheres, then the inactivation of enzymes, which Dickens reports, may be a causative factor As a field for further research, oxygen poisoning remains wide open The relatively slow and deliberate evolution of auras, akin to those of epilepsy, is unique to oxygen poisoning and should be further exploited by experimental workers Further study of the various patterns of cortical dysrhythmias before convulsions may contribute to the knowledge of the mechanisms of epilepsy

It has been demonstrated that the dangers of oxygen poisoning are far greater than previously was realized. The variations of tolerance between individuals, the variations of tolerance of each individual, the impairment of tolerance with work and under water, all make diving on pure oxygen below 25 feet of sea-water a hazardous gamble. The only possible conclusion is that such tensions of oxygen should be avoided scrupulously

The Distaff A renewed expression of appreciation is in order on the continued publication of this timely periodical by the Woman's Auxiliary of the State Society, of which Mrs Harry F Pohlman, of Middletown, is the current president The Distaff is to be issued in July, October, January, and April, 1947-1948, under the guidance of Mrs Lee R Sanborn, editor, and Mrs Alfred L Madden, associate The contents of these issues of the Auxiliary's periodical are well worth the attention of our membership, for they reflect admirably the activities of this important organization Moreover, a signal honor which has come to the State organization is the election of one of its most faithful and enthusiastic members to the presidency of the National AuxiliaryMrs Luther H Kice, who has long been identified with various community activities, particularly in Nassau County Her election to this high post is a fitting reward for her years of past Auxiliary service

Our congratulations and good wishes go forth to our doctors' wives for their help in our problems. The continued growth of the Auxiliary is to be anticipated. Certainly the usefulness of a publication of the excellence of *The Distaff* can contribute much to this end

New Editor. We welcome Dr Joseph Garland to the ranks of the editors of state journals He has recently been appointed as editor of the well-known New England Journal of Medicine, to succeed the late Dr Robert N Nye

Roosevelt Distinguished Service Medal In the belief that some of our members may have missed the announcement of the award for 1947 to General Omar Nelson Bradley, we reprint the citation herewith in part

As head of the Veterans' Administration he has confronted difficulties more complex, it has been said, than the invasion of Europe He has increased to an extraordinary degree the efficiency of the organization which deals successfully with upward of fifteen million veterans when, before him, it dealt incompetently with five. He has cut red tape, expelled the "chiselers," raised the standards of medical care and hospital management, and defied the demagogues seeking to exploit the veteran for their own ends. The future of the ex-GI, he has said, "lies in honest opportunity rather than special privilege. We dare not benefit one group of the American people at the expense of another."

A well-deserved tribute to a courageous gentleman May his work go on

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### Scientific Articles

### SURGICAL PROCEDURES FOR CARCINOMA OF THE RECTOSIGMOID AND RECTUM

CHARLES GORDON HEYD, B A, MD, FACS, DMSc New York City

In NO field of abdominal surgery has there been such significant progress in the last two decades as in carcinoma of the colon and rectum There has been a constant lowering of operative mortality, a lessening in hospital days an increasing rapidity in convalescence and a noteworthy increase in the percentage of cures

Many factors have contributed to these attain First, the increasing psychologic demon stration of bowel consciousness as exemplified in colon and rectal clinics, (2) the marked advance in technical procedures, (3) an ever-accelerating rate of operability (4) a remarkable accuracy in diagnosis (5) the physical survey and adequacy of preoperative preparation, (6) the selective variety and progress in anesthesia, (7) the inhibition and control of infections by the sulfona mides and penicillin, (8) the extensive use of intravenous therapy for anemia, hypoprotinemia and dehydration, (9) the completeness and maintenance of relatively normal physiology by adequate postoperative therapy, and finally (10) the ability to perform and maintain either a temporary or permanent colostomy in a hygienic status with only minor social disabilities to the patient

It is reasonable to anticipate better results as our present knowledge becomes more widely known and further advances are made in all of the factors enumerated Probably the most discussed aspect in the surgical treatment of cancer of the rectourmoid and rectum is the important question of preservation of the sphincteric mechanism of the normal anus. An affirmative or negative answer to this query must always be made at the time of operation and based upon an appraisal of all the factors revenled after the abdomen is opened. The answer will depend largely upon the operative mortality, the im mediate recovery and the future "cure" Excluding true anal cancer from our discussion, which will eventually mean an abdominopermeal resection of the entire rectosigmoid and rectum we may consider all carcinomata of the rectum and rectosigmoid as being placed in one general group

The most complete diagnostic examination including proctoscopy, x-ray examination and biopsy, will not be able at all times to determine accurately (a) operability, (b) curability and (c) type of resection. In every carcinoma in the area under discussion there are a series of pathologic changes induced in the bowel tube that are initiated by the cancer but are not of themselves cancerous The cancer from the very beginning of its course occasions secondary changes that are of great importance in deciding what technic is to be employed There are certain sequential reactions on the part of the large bowel to a destructive and irritating lesion such as cancer There will be varying degrees of obstruction with stasis, with inflammation and edema of the provimal bowel There will be the local plastic peri toneal changes in the area of the neopleam with either metastatic or inflammatory adenopathy Both or only one may be present but usually both will be As the result of these factors there is a high augmentation in the number virulence and character of the associated bacteria. The rectal segment will be a living test tube of virulent bacteria, of blood, pus mucus, and degenerating cancer cells All of these associated conditions, due primarily to the inflammatory phase of the neoplasm, will be corrected by a temporary Devine colostomy Experimental surgery on dogs has shown conclusively that if a segment of bowel is absolutely and completely defunction alized it is readily debacterialized. A Devine colostomy completely defunctionalizes that portion of the bowel distal to its orifices The follow ing changes rapidly ensue in such a defunction alized segment of the large bowel (1) the hyper

All cancers of this segment of the large bowel are associated with varying degrees of inflammation which is progressive and coexistent with the cancerous progress. In the appraisal and selection of the type of operation the surgeon has a choice of only two procedures an abdominoperineal resection with a permanent colostomy or a resection and anastomosis of the bowel ends with preservation of the anus. I believe the latter procedure should always be preceded by a temporary colostomy of the Devine type.

Presented at the 14I t Annual Meeting of the Medical Society of the State of New York Section on Gastroenterology and Proctology May 8, 1947

trophy, dilatation, edema, and myositis resolve, (2) the segment loses its bacterial potency, (3) complete rest is assured to the intestine tube above and below the neoplasm, (4) the local peritoneal reactive changes subside. In brief, the bowel segment returns to a relatively normal status except in the immediate area of the neoplasm.

Other desiderata of great value are obtained in addition to those indicated above

- (1) The performance of a Devine colostomy in the right upper quadrant is a nonlethal procedure. We have performed 40 successive Devine colostomies without a mortality arising from the colostomy.
- (2) The Devine colostomy is easily accomplished, it allows a complete abdominal exploration and determination of (a) the presence or absence of metastases in the liver, (b) of local pelvic implants, (c) thorough palpation of bowel and tumor, the mobility, its extension, the amount of local inflammatory reaction, (d) palpation of lymph nodes in pelvis and at the bifurcation of the abdominal aorta 12

In short, such an exploration permits a general appraisal of many factors and permits the surgeon to decide the issue between resection with preservation of the sphincter plus a temporary colostomy, or abdominoperineal resection with permanent colostomy It is my opinion that in no other way can a decision to resect and preserve the sphincter be made. The responsibility is a tremendous one, and time will demonstrate by recurrence the wisdom of such a decision certainly better for a patient to have a permanent colostomy and no recurrence than to preserve the sphincter at the cost of recurrence I do not beheve that the same results can be accomplished by resection and eccostomy at the time of opera-I am convinced that only complete diversion of the fecal current by a colostomy, with an interval of ten days to two weeks before resection. is the best way to have all the factors in favor of the surgeon when he makes the decision between resection and anastomosis with preservation of the sphincter, and abdominoperineal resection with loss of the sphincter and a permanent colostomy

There is another factor of great importance in the sequence I have suggested. The patient within two or three days after the preliminary Devine colostomy has complete lower bowel rest, with rectal irrigations the bleeding subsides, the diarrhea disappears, the appetite improves Psychologically, he sees his improvement, his morale returns, and he faces the next phase of his surgery with equanimity. A further gain is that almost immediately after the resection the patient can begin to take fluids and eat. The whole left

bowel is, in theory and fact, completely separated from the patient's gastrointestinal tract decision is made for resection with preservation of the sphincter, the colostomy after six to eight weeks may be terminated easily, without a trip to the operating room and without an anesthesia. by applying the Devine or Debakey-Ochsner crushing clamp After the clamp has been in situ for twenty-four hours and the screw turned to its maximum, the patient may return home for five days to a week when the spur is cut through and the fecal current passes from right to left colon A word of caution must be introduced The spurcrushing clamp must not be applied until x-ray examination demonstrates complete healing of the anastomosis, absence of leakage, and free un impeded normal bowel lumen

The principles suggested above may perhaps be best appreciated by a synoptic account of a recent case

S C, a man 62 years of age, consulted me on September 20, 1946, with the complaint of bleeding and diarrhea His past history revealed that he began to have diarrhea with bleeding in January, 1945, which resulted in the patient's going to the bathroom frequently and expelling small quantities of fecal material with mucus and blood. A barum colon enema examination was performed in April, 1946, and revealed "an obstructive condition at the upper portion of the rectum " The patient was ad mitted to the Post-Graduate Hospital on September 28, 1946 Under cyclopropane anesthesia a proctoscopic examination was made and revealed a large flat ulcer involving the entire circumference of the bowel 10 cm from the anus The histologic examination of the tissue was reported as adenocarcinoma On October 1, 1946, through a right upper rectus incision, a Devine colostomy was performed approximately the level of the cul-de-sac of Douglas there was an annular carcinoma involving the entire circumference with approximately a 75 per cent degree of obstruction, and no metastases could be demonstrated in the posterior rectal tissue or in the

Eleven days after the Devine colostomy, October 12, 1946, under cyclopropane curare anesthesia a lower left rectus incision was made and five inches of the sigmoid, rectosigmoid and two inches of the ampulla of the rectum were excised en masse, and an end-to-end anastomosis was performed. The abdominal meision was closed with through-and-through Malin stainless steel wire sutures. The pathologic examination of the tissue removed was reported as follows "adenocarcinoma of colon, chronic lymphadenitis of paracolic lymph nodes, absence of tumor metastasis in paracolic lymph nodes, polypoid adenomata of colon, arteriosclerosis of branch of mesenteric artery"

The patient made an uninterrupted recovery and was discharged from the hospital on the twenty-second postoperative day. The colostomy was working well and forty days after the resection a banum contrast enems showed "an obstruction in the sig-

moid just below the rectal ampulla, probably due both to operative intervention as well as local inflammatory changes and possible perforation '

On the forty-seventh day a sigmoidoscopic examination showed an inflammatory area three inches in from the anal margin with almost 90 per cent occlusion. In the meantime the patient showed a remarkable gain in weight and on January 11 1947 ninety-one days after his resection a second barium colon enems examination was reported as follows "retrograde contrast calcium showing a foreshortening of the sigmoid with moderate con striction at the anastomotic site was observed.' In brief it required in all about three months for the inflammatory obstruction at the site of the anastomosis to resolve

Now reassured that the left colon was intact and without obstruction, the patient was re-admitted to the hospital on January 18 1947 in the ward of the hospital and without any anesthesia the Devine clamp was applied. Four days later the patient was allowed to return home with the Devine colostomy clamp still in situ. On January 27 the Devine clamp was removed Finger palpation through both col ostomy stomata showed a 'crush through orifice between the ascending and descending loops approxi mately 3 cm in diameter On March 21 1947 or somewhat over five months after the resection the patient had normal bowel movements the left col ostomy stoma was closed and the right colostomy stoma was contracted and closed to a diameter no wider than a pencil. On proctoscopic examination the instrument passed the anastomotic line easily and revealed some remaining granulation tissue at the anastematic junction.

In the chronologic narration of this patient's history a number of observations may be made

- 1 The technical procedures of a resection low down at the pertioned reflection of Douglas are inherently difficult, and the operation requires a relatively long time to complete
- An anastomosis without some leakage is an infrequent occurrence
- 3 Postoperative inflammatory obstruction at the anastomotic line is an almost invariable sequela
- 4 The presence of a preliminary colostomy of the Devine type allows the patient to maintain nourishment and make a quick recovery except for the temporary presence of his colostomy
- 5 The number of cases susceptible to this type of operation will be extremely limited
- 6 The results on a five-year basis must be watched with interest and only then can conclusions be drawn as to the final results

The narration of this patient saurgical odyssey also reveals a number of interesting features The long history of bowel disability would suggest inoperability and only a palliative colostomy. However, upon an abdominal exploration during the performance of the Devine colostomy it was found that the pathologic picture was in the

judgment of the surgeon satisfactory for resection with preservation of the sphincter terval between the colostomy and resection was of great advantage to the patient through the natural channels could be forced The care of the colostomy with a Trusk colostomy cap was simple. The complete defunctionalisa tion and rest of the entire left colon and rectum were immensely important both physiologically and psychologically The eleven days between the stages allowed recession of the inflammatory processes in the area of the tumor. The patient approached the second operation with confidence and a sense of well-being— the worst was over The operation was difficult and time consuming the anesthesia-cyclopropane and curare-was all that a surgeon could desire The convalescence was uneventful the highest temperature was only 102 F, and oral feeding began almost immediately after operation However there were local complications at the site of the resection in the form of inflammatory obstruction and leakage. It has been my experience that complete healing at the site of the anastomosis requires more time than is usually considered necessary Lenkage in a minor degree is an almost constant concomitant probably due to lack of complete peritoneal covering of the bowel ends. Both the obstruction and the leakage cleared up and dwappeared The only professional requisite was patience upon the part of the doctor and cooperation upon the part of the patient

The technic of end to-end anastomosis and the abdominoperineal resection are so well and adequately described that no further comment is required. However I am somewhat surprised that the advantages of the Devine colostomy are not more widely known or employed. The technic is not difficult and the functional result is always good whether employed as a temporary or permanent colostomy.

In conclusion, a preliminary Devine colostomy would seem to be the surgical procedure of choice as the first stage for all operations on the rectosigmoid and rectum for carcinoma. At the time of the Devine colostomy the decision is made a permanent Devine colostomy and abdominoperineal resection and/or a temporary Devine colostomy and resection with preservation of the aphincteric mechanism of the anus by resection and end-to-end anastomous Many investigators have indicated that downward metastasis in cancer of the rectum is extremely rare and apparently occurs only in moperable cases decision to save the sphineteric mechanism always will be a difficult one. A detailed statistical study five or ten years from now will indicate whether we have been overly sentimental in attempting too many low resections with preservation of nor

mal bowel evacuation at the price of recurrence of the cancer

116 East 53rd Street

#### Discussion

John D Stewart, M.D., Buffalo -- We must all admire Dr Heyd's open-minded attitude toward the question of resection of rectal or rectosigmoidal carcinoma with preservation of the sphincter tainly, I myself have a strong prejudice against such a procedure, and for reasons which Dr Heyd has clearly pointed out The chief objective of any operation to cure cancer is a cancer cure, so long as reasonably good health is assured the patient thereby The moment the surgeon becomes distracted from this goal by considerations of convenience, plastic or cosmetic factors, or surgical virtuosity, the percentage of five-year cures begins to dwindle I believe some rectal cancers can be cured by resection and end-to-end anastomosis, but I believe a far higher percentage will be cured by the combined abdominopermeal excision, which includes lymph nodes and blood vessels in the zone of spread of the disease

Furthermore, no matter how skillful the surgeon, as Dr Heyd has pointed out, there will be stenous of the lumen and malfunction of the preserved anal sphineter in many instances of resection and anastomosis

The dissatisfaction with cecostomy as a preliminary measure in decompressing the colon obstructed by carcinoma of the rectum, as expressed by Dr Heyd, unfortunately, is often quite justifiable. I have hesitated, however, to use the Devine colostomy in the presence of obstruction, for it involves an intraperitoneal suture line in an obstructed colon. Instead I do a simple loop colostomy in the right upper quadrant where there is significant obstruction. This has yielded quite satisfactory results in my experience. I have never quite dared to palpate the growth and the region of the growth to determine operability at the time of doing colostomy, for fear of causing dissemination of the infection always present.

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#### STREPTOMYCIN USED IN CLOSING DRAINING TUBERCULOUS SINUSES

Streptomyon has now proved effective when used in the treatment of draining tuberculous sinuses According to the former Clinical Director of the Veterans Administration Hospital at Oteen, North Carolina, this is one of the most impressive results in the treatment of tuberculosis in man by the new antibiotic

Writing in the September 20 issue of the Journal of the American Medical Association, Benjamin L. Brock, MD, states that 11 out of 12 patients, with a total of 60 draining sinuses of tuberculous origin, showed outstanding signs of improvement after being given injections of streptomycin over a period of months in the Veterans Administration Hospital at Oteen.

In the 12 cases reported by Dr Brock, 15 per cent of the 60 snuses closed within one to four weeks, and after 12 weeks of streptomycin treatment 80 per cent had closed. (After 20 weeks, all but one sinus had closed) In 11 out of the 12 cases the patients' appetite also improved, and they gained an average of 15 pounds

Certain toxic reactions were observed Dr Brock's patients did not complain of headaches, a common reaction among white patients, but he believes that there is a higher threshold for pain exhibited by negroes, and only one of his patients was white Many were bothered by dizziness, however, and three became feverish after the drug was administered None of the reactions was severe enough to justify discontinuing the streptomycin treatment

"These cases have not been followed sufficiently long to determine whether streptomycin has produced a permanent closure of the sinuses," Dr Brock writes, "but the promptness with which they

healed after the initiation of treatment is one of the outstanding observations in this series"

In another article appearing in the same issue of the Journal, C P Mehas, M D, and Wayne E. Traux, M.D, from the Oakland County Tuber culosis Sanitarium of Pontiac, Michigan, conclude that streptomycin administered early in the course of tuberculous meningitis is capable of arresting the process. They cite a case in which streptomycin was given both by muscular and spinal injections, and in which spinal injections alone suppressed the disease for a long time without producing a resistant strain of the organism.

In this case the toxic reactions seem to have been severe Intraspinal administration of the drug finally had to be stopped because the patient became feverish, stuporous and mentally confused, and even after this she had a convulsion. Her hearing and coordination were also definitely impaired. The tuberculous meningitis itself would have been considered incurable before the advent of streptomycin, however, and the doctors found evidence to show that the changes due to toxic reaction may not be

permanent
In the same publication appears still a third favorable report on the new antibiotic, this one by Eman uel Appelbaum, MD, and Cyrille Halkin, M.D, of New York They cite a case of tuberculous meningitis associated with generalized miliary tuberculosis, another disease which was formerly 100 per cent fatal, in which "complete clinical arrest followed the use of streptomycin" Except for one short episode of dizziness and the appearance of a transitory rash, in this case the drug was well tolerated by the patient, a child

### COMPLICATIONS OF ABDOMINOPERINEAL RESECTION OF RECTUM FOR CANCER

GEORGE E BINKLEY, M B (Tor) and MICHAEL R DEDDISH, M D, New York City (From the Memorial Hospital)

THE surgical treatment of rectal cancer has shown marked improvement during the past two decades. A higher percentage of patients is now being operated upon than at any time in the past. Complications are less numerous and the percentage of fatalities has been reduced greatly

Miles, of London in 1908 described an operation for the cure of cancer of the rectum <sup>1</sup> The foundation of this operation was based on the assumption that complete removal of the primary lesion and the draining lymphatics was necessary to produce the highest percentage of clinical cures. Despite his enthusiasm and the encouraging early results the advantages of the Miles one-stage abdominoperineal resection were not fully appreciated by American surgeons until the late twenties and early thirties. The preliminary reports revealed numerous serious complications with an associated high operative mortality.

The operative mortality of the one-stage Miles abdominopenneal resection has been reduced greatly In our clinic, from 1930 to 1939, the mortality rate was 16 per cent. From 1940 to 1940, it was 2.3 per cent. Beginning in 1939 a sense of 130 consecutive operations was completed without a death

Experience suggests that postoperative complications may be prevented or favorably in fluenced by (1) an adequate preoperative preparation of the patient, (2) treatment while on the operating table, (3) surgical technic, and (4) early recognition with prompt treatment of complications.

Routine preoperative preparation requires a min imum of five days, although in poor risk cases, several weeks may be necessary Cancer of the rectum should be operated upon as soon as convenient, but the average case is not an acute emergency A careful physical examination, which includes the necessary laboratory examination, often will reveal danger signals to be avoided or indicate the treatment to be given. Many patients will show varying degrees of cardiovascular or respiratory disease, enlargement of the proetate, bladder atony, poor kidney function and metabolic disturbances are not infrequent associated findings.

The bowel is prepared for operation by the oral administration of magnesium sulfate and rectal colon irrigations. An adequate cleaning may be

Presented at the 141st Annual Meeting of the Medical Society of the State of New York, Buffalo, Section on Gastroenterology and Proctology May 3, 1947

obtained in this manner within five days. We prefer this technic to sulfonamide therapy

The observations and care of patients while in the operating room should be under the supervision of a physician anesthetist familiar with this type of surgery, if complications are to be kept at a minimum. The anesthetic agent selected and the method of administration is governed by the particular findings in the individual case. Shook is avoided by the administration of blood, blood plasma, isotonic saline, and glucose solutions Patients should be handled carefully between the abdominal and permeal phases of the operation to avoid any sharp drop in the blood pressure

Skilled nursing is imperative during the immediate postoperative period. Deep-breathing is encouraged at frequent intervals as soon as the patient is conscious. Chewing gum and lemon peel are prescribed to stimulate the salivary glands. We believe that this practice prevents the development of acute parotitis, a complication which was not encountered in this group of patients. Movement of the lower extremities with flexion of the knees feet, and toes is advocated as a means of decreasing venous stasis Patients with marked varicosities of the legs frequently are bandaged from the toes to the groins All patients are encouraged to change their position in bed frequently They are allowed out of bed early, if it is thought advisable.

The complications under discussion are those which were observed during the first sixty days after operation in 350 consecutive patients. They were taken from the Colon and Rectal Service of the Memorial Hospital in New York City from the years 1941 to 1946 The operations were per formed by or under the supervision of six differ ent visiting surgeons Complications were widely distributed in the different anatomic systems Some patients had only one complication while others had as many as six or seven. There were eight postoperative deaths an operative mortal ity of 2.3 per cent Although the mortality rate was low, in a small number of cases the postoperative course was stormy One is impressed with the fewer and less severe complications in this period as compared with those which occurred in patients during the previous decade

In the early days of radical rectal surgery shock was of common occurrence but it is now comparatively rare. There were 9 patients with a sufficient degree of shock worthy of mention. The most constant causative factor was excessive blood loss at the time of operation. In the majority of these patients a moderate degree of hypertension and arteriosclerosis was present prior to operation. Two of the patients had mild diabetes.

Bleeding from the perineal wound was not proved to be of a serious nature in this group of patients In most cases there was only a mild oozing beyond that ordinarily expected from wide dissections Control, in such cases, was accomplished by additional packing of the permeal Four patients had sufficient bleeding to warrant the term hemorrhage These were taken to the operating room, the permeal wound opened, the packing removed, and the source of bleeding ligated One patient, an elderly lady, with numerous other complications, had a slight hemorrhage from the permeal wound on the twenty-third postoperative day without serious effects

#### Complications

Cardiovascular system complications were responsible for two deaths Both patients had hypertension before operation Each died of a massive myocardial infarction eighteen and seventy hours, respectively, following operation patients had some degree of cardiac decompensation which was manifest from the third to the thirteenth postoperative days Of this group, 4 had hypertensive cardiovascular disease. 1 had hyperthyroidism of longstanding, and the remaining 4 patients had advanced arteriosclerosis. All recovered promptly after the administration of Tachycardia was observed in three patients, in one of which hyperthyroidism was thought to be the causative factor The others were undiagnosed

Phlebothrombosis and thrombophlebitis are complications dreaded by all surgeons series, 57 per cent of our patients were so afflicted The diagnosis may not always be evident, and the appropriate treatment for the given case is, at times, open to debate Bed exercises to prevent these complications were emphasized routinely, but it is difficult to estimate the benefits of those efforts in a mathematical fashion Surgical trauma is a factor in causing phlebitis Rough handling of tissues, leaning on the patient, especially over the femorodiac region, and inexcusable trauma to the pelvic vessels at operation are possible contributory agents in the failure to re-establish normal venous return postoperatively

There were 6 cases of phlebothrombosis with two fatalities due to pulmonary embolism. The deaths occurred suddenly, without previous symptoms, on the sixteenth and seventeenth

postoperative days Autopsy findings confirmed the diagnosis in both cases Fourteen patients had thrombophlebitis Clinical manifestations appeared from the eighth to the twenty-eighth postoperative days In 2 patients both lower ex tremities were involved The right lower extremity was involved in 5 and the left lower extremity was involved in 6 In 1 man this com plication was limited to the right cephalic vain and apparently was not associated with intravenous therapy In these patients, subjective complaints of vague pain in the lower extremity were often elicited This was described as a local tenderness of a deep sort, particularly in the outer posterior surface of the lower leg

As observed by Homans, the objective signs of thrombosis are in a great degree related to a state in the great muscles of the lower extremities 2 There is an increased firmness on compression and a tendency to resist dorsiflexion of the foot On actual measurement there is an increase of the largest diameter of the calf The clinical chart reveals an elevation of the pulse rate and temperature This clue has been especially em phasized by Bauer and Allen and their associates 3 4 This manifestation most frequently 18 seen on the clinic chart after the patient has leveled off following his operation Circulatory failure to some degree, manifest as faintness or actual loss of consciousness, may result reflexly from dislodgement of a thrombus and pulmonary One patient in our series showed this infarction symptomatology The general circulation may react rather violently to the lodgement of the embolus, and yet may readjust itself within a few hours if no further insult occurs

In the early years in this group of complications, thrombophlebitis and phlebothrombosis were treated by immobilization of the involved extremity Later, the anticoagulants, heparin and dicumarol, were administered, and in one instance the common femoral vein was interrupted At the present time we are emphasizing early diagnosis and the use of anticoagulants

Pulmonary complications are a hazard to any patient who is confined to bed This is especially true in patients to whom an anesthetic has been administered for major abdominal surgery our series, 20 patients (57 per cent) developed pneumonia Bilateral bronchopneumonia was a contributing factor in three of the postoperative Lobar pneumonia, developing on a masdeaths sive atelectasis of the right lung, contributed to the cause of death in another patient Atelectasis occurred in 9 patients Concurrent upper respiratory infections occured in 8 cases In our experience there was no definite relationship between the incidence of wound infections and the incidence of respiratory tract infections as observed by Jones Seven patients (20 per cent)

were observed with pulmonary infarcts 2 were of a massive character and were fatal Three patients had multiple small infarcts, 2 others had evidence of solitary infarction. This disease entity generally is unobserved by the surgeon and it is his tardiness or his failure in detecting it that leads frequently to its much dreaded termination.

Clinically, pulmonary embolism is being recog nized by symptoms and signs often regarded in the past as indications of primary disease of the heart and lungs or perhaps commonplace complaints having no special significance 2. The subjective and objective findings of thrombophlebitis and phlebothrombosis have been discussed under cardiovascular complications Roentgenograms of the lung fields will show evidence of infarction. but if these are small this diagnostic evidence will not be obtained for a few days Electrocardiograms are often helpful in the differential diagnosis of these two closely simulated conditions With such aids to diagnosis in mind, pulmonary embolism can be identified early in a surprisingly large number of cases. When the fact has been established or is strongly suspected medical or surgical treatment may be instituted at once

The gastrointestinal complications have varied greatly in their types and severity Gastric dilatation was noted in 32 cases. In the past, a mortality rate as high as 75 per cent has been quoted for this complication. Early recognition is a factor of greatest importance. This is characterused by an effortless vomiting of greenish brown or black material, a rapid pulse, free perspiration and later definite shock. Acute gastric dilatation may be associated with a mild ileus or be the forerunner of an extensive pentonitis. At times, a considerable nervous element was noted. Ileus, or small bowel obstruction, may be expected in a small percentage of patients undergoing this type of operation Diagnosis and differential diagnosis of these conditions is less difficult today than formerly because of our increased knowledge in interpreting roentgenograms of the intestinal tract and information obtained from the passage of the Miller Abbott or similar intestinal tubes. There were 31 patients with symptoms suggesting ileus or small bowel obstruction Eleven were considered to be ileus, characterized by saymptomatic distention. Sixteen were diagnosed as obstruction of the small bowel The 16 cases of obstruction were first treated by means of the intestinal intubation tube However, 9 of them required operation for complete relief The diag nosis of small bowel obstruction was proved in all cases at operation. The cause was due to a piece of small bowel having become adherent to either the abdominal wall the edge of the mesocolon or the suture line of the pelvic peritoneum. There were 2 other cases who had partial obstruction of the small intestine. One an advanced cardiac,

died of cardiac failure, the other died of general pentonitis.

Necrosis of the distal end of the colon which formed the abdominal colostomy occurred in 9 This complication is encountered in pa tients in whom there has been interference of the blood supply of the sigmoid colon either by ligation of the marginal vessels or too tight a closure of fascia about the colostomy A secondary causative factor may be a marked fall in blood pressure which lasts for several hours after the operation, especially in patients manifesting advanced artenosclerosis or diabetes Treatment of this condition when it is recognized early, consists of "pulling" or "milking" the end of the bowel through the incision until the viable bowel is above the skin margin. Such a procedure usually can be carried out in the patient's room. In only 2 cases was necrosis extensive enough to warrant a transfer of the patient to the operating room. Perforation of the large intestine occurred in 2 patients Perforation of the descending colon followed irrigation of the colostomy with a catheter The other perforation was of the cecum and occurred on the twenty-first postoperative day This latter patient had polycythemia vera and perforation was thought to be an embolic phenomenon

Retraction of the colostomy into the abdomen occurred in 2 cases. One occurred on the fourth day postoperatively following an episode of vomiting due to gastric dilatation. At operation it had been noted that this patient had a short, thick, inelastic mesocolon. Recovery was with out incident. The other occurred on the sixth postoperative day after an attack of vomiting. This patient died of a peritonitis. Strangulation of an inguinal hernia occurred in 2 patients. In each case this complication occurred in the third postoperative week and required resection of the involved portions of the small intestine.

Hematologic and brochemical complications are of frequent occurrence in patients operated upon for cancer, especially those suffering with cancer of the colon and rectum For the past eight years we have given a great deal of atten tion to the maintenance of satisfactory hemoglobin and blood chemistry levels in all patients during the early postoperative period By so doing a much larger percentage of very poor surgical maks have been successfully operated upon Hypoproteinemia is one of the most common com plications. There is considerable evidence to show that a persistent hypoproteinemia may result in tissue edema, ascites altered motility of the gastrointestinal tract wound descriptions, and an increased susceptibility to infection. In an earlier series of cases studied in our clinic, hypoprotesnemia was noted preoperatively in 38 per cent of the patients. After operation, 88 per cent

were in a state of hypoproteinemia during the first postoperative week \*

In this present series, hypoproteinemia of a degree sufficient to warrant aggressive treatment occurred in 68 patients (19 4 per cent) In most instances, the hypoproteinemia is associated with an anemia Marked anemia was observed in 18 6 The degree of these per cent of the patients two states or conditions varied as did the response to treatment Infection is a factor which interferes with the maintenance of normal hemoglobin and serum protein levels Convalescence is most satisfactory in patients with a hemoglobin above 75 per cent and a serum protein not below 55 mg per 100 cc of blood Careful and repeated checks for anemia and hypoproteinemia. together with the estimation of serum bilirubin in all cases where transfusions are indicated, afford a sound working foundation for preventing and relieving these complications Transfusions of whole blood is the treatment of choice in most Blood plasma is given when only hypoproteinemia is present, or in those cases in which a high serum bilirubin level contraindicates the use of whole blood In the second week of convalescence, anemia and hypoproteinemia may be influenced by diet, protein supplements, intramuscular injection of crude liver, vitamin therapy, and satisfactory colon evacuation

Transfusion reactions have presented a real problem in the postoperative care of our patients Fourteen severe transfusion reactions were ob-They were evident as chills, fever, allergic and anaphylactic reactions, and hemolysis Hemolytic transfusion reactions are unfortunately much more frequent than is usually suspected Every effort should be made to eliminate Competent laboratory assistants this hazard are most essential to establish the compatability of donor blood The presence of pyrogens or impurities in solutions or improperly cleansed glassware or tubing may cause febrile reactions critically ill or extremely anemic patients, these febrile reactions may result in a fatal outcome \* Recent experiments by Bing suggested that fatal human reactions occur with markedly reduced alkalı reserves, as ın severe shock 10 There were no fatal transfusion reactions in this series of patients studied We believe that the administration of blood plasma rather than whole blood to patients with high serum bilirubin levels has reduced the number of these complications In one patient an azotemia and hemolytic Staphylococcus aureus septicemia occurred, which was responsible for her death Azotemia was present in one patient who was diagnosed as an advanced cardiorenal risk preoperatively Another case of unexplained septicemia was observed on the second postoperative day An anaerobic streptococcus culture was obtained following a febrile

reaction Repeated blood cultures did not demonstrate the organism

Urinary tract complications are of frequent occurrence They have received considerable attention from both rectal and genitourinary sur-Efforts have been made, and still are being made, to decrease the number and seventy of these complications following radical surgery for Bladder dysfunction is cancer of the rectum most common and occurred in 466 per cent of our patients Of the 350 patients, 71 had mild, 57 had moderate, and 35 had severe bladder dysfunction The mild type is of little more significance than difficulty in voiding after anal and abdominal operations The moderate type is more severe but responds to conservative treatment, such as repeated catheterization or the placement of an indwelling urethral catheter for a The severe type requires either prolonged wearing of an indwelling urethral catheter or surgical intervention Surgery may be necessary either for relief of obstruction or to provide support to the bladder

The cause of bladder dysfunction is open to debate. It is most commonly encountered in patients who have received very wide radical pelvic dissection, whereas those with a conservative operation are seldom severely affected. Nerve section or nerve trauma as a causative factor seems limited to the mild or moderately severe group, and thus it seems to be only one of the numerous factors. Cystitis is often associated with bladder dysfunction. It, in itself, may be a real causative factor. There were 56 cases of proved cystitis in this group and undoubtedly there were many other cases in which the urine was not cultured.

The most constant contributing factor to bladder incontinence is the interference with the normal support of the bladder and urethra The area supporting the neck of the bladder warrants greatest consideration 11 This is the area most interfered with in our wide dissections of advanced pelvic disease, where excision of supporting muscles and fascia is necessary Pelvic fascia of poor quality and poor pelvic supports also suggest a predisposing factor in the female, while enlarged prostate and associated atonic bladder in elderly males must not be overlooked Appraisal of the above factors by the surgeon offers a working basis for the prediction of the degree of bladder dysfunction in a given case This complication is seldom fatal and most patients regain normal control

Hematuria of a mild form was encountered in 4 patients. The cause was attributed to the use of sulfonamides. There was one case of proved pyelitis. The patient was treated by dilatation of the ureter and drainage with excellent results. There was one case of a perforated urethra in a man patient resulting from an attempt at catheterization

Operative wound complications were not numerous or unduly severe. There were twenty mild wound infections. Some of these were not more than superficial skin infections and the majority were localized. Infected hematomas were largely responsible There was one severe wound infection associated with peritonitis The patient died from an overwhelming infection Pentonitis was observed in 4 patients (2.28 per cent) In two instances it was generalized and resulted in the death of both patients. A marked wound infection in one case and retraction of a colostomy in the second were causative factors. The other instance was due to perforation of the sig moid colon following irrigation with a rubber catheter Localized pelvic peritonitis followed a perineal wound disruption There were two disruptions of the abdominal wound One occurred in a catgut suture closure of the abdominal wall. the other in a steel wire closure. The technic of abdominal wall closure with alloy steel wire established by Jones has been used routinely for the past five years.13

One unusual case listed in this series as poor abdominal wound healing due to vitamin C deficiency should be mentioned. Inspection of this patient's abdomen on the fifth postoperative day revealed serosanguineous fluid on the dressing sug gestive of impending wound disruption. The pa tient was taken to the operating room and inspection revealed the wire sutures to be intact with fluid coming from about the coloatomy and between the sutures A dramatic response in wound healing was later demonstrated with the administration of large doses of vitamins A and

There was one partial disruption of the pelvic floor which responded to conservative treatment by placing the patient in deep Trendelenberg posation and placing vaseline packing within the wound In nine instances there was slow healing of the permeal wounds. This usually occurred in very obese patients and in three instances was associated with a severe hypoproteinemia

Among other complications were 7 cases of mental depression (2 per cent) in this series. In 3 cases mental institutional care was necessary Two had suicidal tendencies and it was believed that, in the 2 patients with suicidal tendencies the depression was precipitated by the realization that they had permanent colostomies. The other had previous evidence of involutional melancholia. However, one patient was found to be ad dicted to the use of morphine for a long interval and later died in a mental institution ond patient recovered after a short interval of hospitalization

One young man suffering from essential hypertension developed left facial weakness and paresis of the right extremities for approximately one week postoperatively. Come developed in one diabetic patient on the fifth postoperative day This patient never regained consciousness but did live for several months. Autopsy revealed brain metastases

Abdominal cramps of undetermined nature were observed in 5 patients having considerable mental overlay

Hiccough occurred in six instances Two per sistent cases were associated with partial intesti One had gastric dilatation nal obstruction The other three instances were mild and of short duration This symptom may in some instances be an ominous sign of peritonitis due to devital ized bowel

Cholecystitis was observed in two instances Both responded to conservative therapy one case, cholelithiasis was demonstrated at operation

#### Summary

- Complications and postoperative deaths due to abdominopermeal resection of the rectum for cancer have been significantly reduced in the past five years
- An operative mortality of 2 3 per cent, in a senes of 350 consecutively operated patients, is reported
- Thorough evaluation and preparation of the patient have extended the limits of operabil ity
- The maintenance of essentially normal hematic and biochemical levels has shortened the convalescent period

Genitorumary tract complications, in some degree, occurred in 46 per cent of the patients Ten per cent were severe enough to require opera tive intervention for relief

Coronary occlusion pulmonary embolus peritonitis, phlebothrombous and thrombophlebitis were the most severe complications.

121 EAST 60TH STRFFT

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### ABSCESSES OF THE DEEP PERIRECTAL SPACES

Their Significance, Diagnosis, and Treatment

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IT IS not the purpose of this paper to discuss accepted principles of fistula surgery, but to describe one of the more serious types of anorectal infection—the deep perirectal abscess, which is on most occasions overlooked, and, as shown by statistics, on many occasions, improperly treated

For the purpose of clarity, abscesses of the anorectal region may be divided into those below, those within, and those above the levator muscles,

as shown in the accompanying diagram

quently the physician concludes that the patient is exaggerating his complaint. This patient must be given every benefit of doubt and should be referred to a proctologist at once

Delay in surgical treatment permits (1) relatively simple abscesses to become complicated by rupture from one anatomic space into another, (2) necrosis of functionally important anatomic structures, (3) rupture into the rectum (a second ary opening), thereby producing a true anal rectal fistula. As a result, more extensive and in

#### Significance

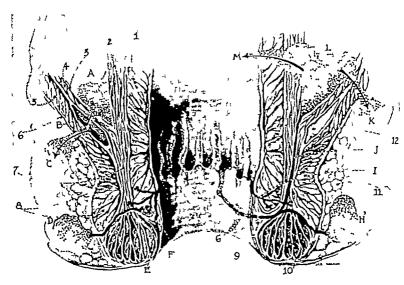
Though the onset of pain from a deep abscess may be gradual or abrupt, it is not long before the patient seeks the advice of his physician

Whereas superficial anorectal infections often show an area of redness, swelling, or induration, the deep variety usually present no external evidence of the suspected infection. Due to this fact, perirectal abscesses go unrecognized for indefinite periods. On many occasions, it is not until the patient reaches the specialist that a correct diagnosis is made and proper surgical treatment instituted. If the specialist is to be of any real service to these patients, the diagnosis must be made by the physician at the time of the first examination.

The family doctor readily will diagnose and institute proper treatment for the usual variety of anorectal conditions. However, unless he has had special proctologic training, or experience with perirectal abscesses on some previous occasion, he is very apt to conclude that there is nothing wrong with this particular patient's anorectum. Therefore, I stress that the patient who complains of anorectal pain, and who, at the time of examination, shows no apparent cause for his discomfort, is often suffering from one of the most serious anorectal conditions. Only too fre-

Presented at the 141st Annual Meeting of the Medical Society of the State of New York, Buffalo, Section on Gastroenterology and Proctology, May 8 1947 creasingly difficult surgical procedures become necessary

In most cases, further extension ceases the moment the abscess is uncapped and tension re-I agree with Fansler, who states, "Contrary to the belief of many, we believe that the earlier these abscesses are drained, the better"1 In our opinion it is a mistake to treat these conditions expectantly and wait for the abscess to "point" The surgeon who waits for any penanorectal abscess to "point" must have a rather insecure feeling as to his own knowledge of anorectal anatomy and is afraid that, by making an incision several inches deep to reach the abscess, he will destroy functionally important structures and end up with an incontinent patient Perirectal abscesses never "point" externally, unless secondary involvement of superficial spaces has occurred They are more likely to "point" or rup-Since these abscesses ture high into the rectum should never be drained through the rectum, utmost caution should be used in making digital and instrumental examinations, so as not to rupture the abscess while making the diagnosis Patients presenting the most extensive fistules either have failed to go to their physician, and the abscess has eventually ruptured, or the physician has treated the patient with suppositories, hot packs, and sitz baths, rather than immediate It is just as much a mistake to prescribe medication for pain, prior to the time the



Coronal section, somewhat schematic, made through the middle of the anorectum, showing the definite anatomic pathways as they occur in anorectal infections and the usual method of 'break through (as shown by the arrows) from one perirectal space to another (Dissection by author)

- Circular muscle layer of rectum.
- Longitudinal muscle layer of rectum.
- 3 Levator lascia.
- Superior layer of levator muscle.
   Interior layer of levator muscle.
- Anal fascia
- Combined longitudinal muscle layer of rectum.
- Deep external sphincter muscle of anus.
- 9. Anal intermuscular septum.
- 10 Subcutaneous external sphincter muscle of anus.
- 11 Fat of ischioanal fossa.
- 12 Lateral extension of posterior levator space.
- A Abscess in pelvirectal space, as a result of 'break through' from the lateral extension of the posterior levator space (Uncommon)
- B Abscess in lateral extension of posterior levator space (Common)
- Abecess in ischioanal fossa, as a result of 'break through' from the lateral extension of the posterior levator space (Rare)
- D Abscess in the ischicanal fossa, with fistula tract connecting the circumanal space and passing outward between the subcutaneous and deep portions of the external anal sphincter muscle (Very common) (Super ficial or perianal variety)
  - Abscess in the circumanal space, formed around a lower branch of an anal duct.
  - Subcutaneous fistula tract, point of origin in an anal crypt and duct (Very common) (Superficial or perlanal variety)
- G. Fixtula tract originating in an anal crypt and duct, thence passing laterally along the circumanal space to "break through into one of the ascending tracts in the combined longitudinal muscle layer of the rectum, to form an abscess in the polvirectal space (Common)
  - $H_{\bullet}$  Abscess in the isohioanal fossa, which originates as in G (Very common) (Superficial or perianal variety) I Schematic representation of an anal duct, penetrating the internal sphincter and the combined longitudi
- nal muscle layer of the rectum. Anatomic pathway within the combined longitudinal muscle layer of the rectum, connecting the pelvi rectal and circumanal spaces (the level of the anal intermuscular septum)
  - K, Abscess in ischioanal fossa, as a result of 'break-through from the pelvirectal space (Very rare)
- $L_i$  Abscess in pelvirectal space, origin in anal crypt and duct, as explained in G (Common)  $M_i$  Abscess of pelvirectal space which has ruptured through the entire bowel wall into the rectum, thereby forming a high secondary opening within the lumen of the rectum (Uncommon)

patient consents to necessary surgery, as it is in the case of the acute abdomen This rather common practice of relieving the patient's pain gives him a feeling of false security and he will often refuse or postpone the inevitable surgery, much to his own detriment

Buie,<sup>2</sup> in reporting the statistics on 1,000 consecutive fistulectomies performed at the Mayo Clinic, stated, "Of all the patients, 46 8 per cent had been operated on once previous to admission to the Chine. 143 per cent twice, 41 per cent three times, 0 9 per cent four times, 0 7 per cent five times, 04 per cent six times, 04 per cent seven times, 0 1 per cent eight times, 0 2 per cent twelve times, and 01 per cent fifteen times" Fansler, in discussing Buie's paper, stated that the above statistics corresponded to his own experience 1 He also stated, "If that percentage of persons with fistulas are not cured by the first operation, there is something wrong with the way fistula surgery is being done" He felt that the cause for failure in these cases was due to the fact that in many instances there was a lack of conviction on the part of the surgeon that most rectal fistulas have a primary opening in one of the crypts of Morgagni 1

While Fansler is correct in the above statements, I believe the principal cause for failure has been due to the surgeon's lack of knowledge of the anatomy of these deep spaces, together with failure, at the time of fistulectomy, to remove the definite, anatomic pathways by which these spaces

become infected

#### Anatomy

The anatomy pertinent to infections of the perirectal spaces will be reviewed briefly

Pelmrectal Spaces — These are two in number, a right and left, lying anterolateral to the rectum, and are filled in with areolar tissue They are situated on either side of the pelvis and lie above the levator muscle (Figs 2 and 3) The superior boundary of these spaces is formed by the peri-The inferior boundary is that portion of the parietal layer of the pelvic fascia which covers the superior surface of the levator muscle (levator fascia) The medial boundary of these spaces is formed by the visceral layer of the pelvic fascia as it surrounds the pelvic viscera In men these comprise the rectum, bladder, and prostate, in women, the rectum, uterus, vagina, and bladder The lateral boundary is the obturator fascia (Fig. Anteriorly, the spaces extend to the point 3, 17) of junction of the parietal and visceral fascias Posteriorly, the pelvirectal spaces are separated from the retrorectal space by the rectal stalks (Fig 3, 18)

Retrorectal Space — The anterior boundary is formed by the visceral fascia on the posterior sur-

face of the rectum, the posterior boundary by the levator fascia and that portion of the pelvic fascia which lies anterior to the sacrum and coccyx, the lateral boundaries by the rectal stalks, on either side. This space likewise lies above the levator muscle and is filled in by arcolar tissue (Fig. 3, 9)

The Posterior Levator Space —This intralevator space is entirely bounded by subdivisions of the levator muscle (Fig 3, 3, 1-12) 3-5 It is a "wedge or V-shaped" space lying against the rectal wall It is situated between the superior and inferior layers of the levator muscle and surrounds the rectum posteriorly and laterally, like a horse-The medial boundary is formed by the combined longitudinal muscular layer of the rectum in man, and the same layers of the rectum and vagina in the woman (Fig 3, 5, Fig 1, 7) The superior boundary of this space is formed posterior to the rectum, by the illorectococcygeus muscle (Fig 2, 8, Fig 3, 8), and to the side, by the superior layer of the levator (Fig. 3, 4, Fig. 2, The inferior boundary of this space is formed, posterior to the rectum, by the coccygeal muscular raphe (Fig. 3, 7), and to the side, by the inferior layer of the puborectalis muscle (Fig. 3, 2)

Pathways of Infection to the Perirectal Spaces—In the past, it was assumed that the lymphatics played the most important role in infection of the perirectal spaces. Present-day knowledge of the anatomic pathways, by which each individual space becomes infected, discredits this view 3-5

As the superior (Fig. 3, 6, Fig. 1, 4) and inferior (Fig 1, 5) layers of the levator come in contact with the rectal wall, each layer gives off thin bundles of muscle fibers to the combined longitudinal muscle layer of the rectum In doing 80, they form a series or row of fossules (Fig. 2, 4) with connecting tracts (Fig. 1, J) which extend inferiorly to the circumanal space (Fig 1, G), or the level of the anal intermuscular septum (Fig 3, Infection spreads from the anal ducts to the circumanal space (Fig. 1, G), and thence upwards along these tracts, to the various penrectal spaces These tracts he within the combined longitudinal muscle layer of the rectum essential that these infected tracts be removed at the time of fistulectomy

The primary opening, in cases involving the posterior levator and retrorectal spaces, is found either in a posterior crypt or in a postanal ulcer. The tracts to the retrorectal space he anterior to the corresponding ones to the posterior levator space (Fig. 3, 19), due to the particular configuration of the combined longitudinal muscle layer of the posterior rectal wall

In involvement of the pelvirectal spaces, the primary crypt opening is usually found in the lateral position. When either the anterior or posterior quadrant is involved, the infection

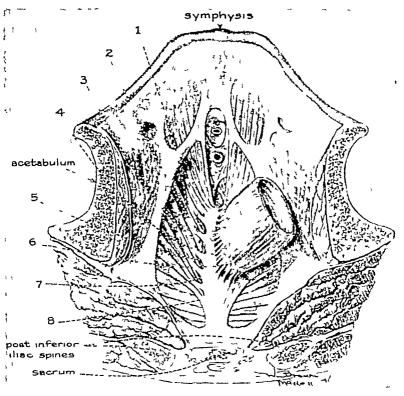


Fig 2. Superior view into dissected male pelvis (looking into the pelvis from above and behind) the rectum being displaced anteriorly and to the right. (Dissection by author)

- 1 Levator muscle-lateral to the point of division into a superior and an inferior layer
- 2, Superior layer of the levator
- 3 Inferior layer of the levator
- 4. The row of fossules, with connecting tracts, which extend inferiorly to the circumanal space (level of anal-intermuscular septum)
- 5 Superior layer of levator forming the superior boundary of the posterior levator space, to the side of the rectum.
- $\theta$  Longitudinal muscle layer of the rectum, giving off fibers posteriorly which units with fibers from the flicoccopyeus and fibers from the levator fascia to form the flicrectoccopyeus muscle.
- 7 The lateral margin of the illorectococygeus musclo—the usual point of "break-through" for absceeces from the posterior levator to the retrorectal space.
- $\delta$  Illorectoeoecygeus muscle (old terminology roctoeoecygeus muscle) forming the superior boundary of the posterior levator space, posterior to the rectum.

spreads along the circumanal space and breaks through along the minute blood vessels, to gain entrance into the tracts which ascend in the lateral wall of the bowel to the pelvirectal space (Fig. 1, G and J)

Occasionally, multiple tracts from a single crypt may extend to form simultaneous abscesses in the various perirectal spaces. Therefore, when more than one perirectal space is involved, the surgeon must search for multiple tract infection.

These abscesses spread according to a definite pattern, which is governed by the mechanical pressure developed within and controlled by the limitations of the individual space involved Thus, infection from the posterior levator commonly breaks through into the retrorectal space at the lateral margin of the iliorectococcygeus muscle (Fig 2, 7) The rectal stalks (Fig. 3, 18) do not form an impervious barrier between the retrorectal and pelvirectal spaces, as previously believed, and extension from the retrorectal to the pelvirectal space is common A spread from the lateral extension of the posterior levator to the overlying pelvirectal space is less common (Fig. 1, A "break-through" from the lateral extension of the posterior levator to the underlying ischioanal fossa rarely occurs (Fig. 1, C) due to the thickness of the inferior layer of the levator muscle In extensive infections. when the surgeon finds an abscess involving the ischioanal fossa and the overlying lateral extension of the posterior levator space or the pelvirectal space, he will also usually find extensive necrosis of the levator muscle of extension is from the overlying space to the underlying ischioanal fossa, and not vice versa, as so frequently stated in the literature (Fig. 1, K)

#### Diagnosis

Regardless of all other findings, the diagnosis of a perirectal abscess is based upon two factors only (1) the history of anorectal pain regardless of type, and (2) the results of the bidigital examination. Regardless of the intensity of the pain, if the patient is reassured and convinced that the examination will be made with the utmost care, the examiner, in almost every instance, will be able to make a fairly satisfactory bidigital examination at the time he first sees the patient

As mentioned before in this paper and elsewhere, 2-5 perirectal abscesses usually show no external evidence of the suspected infection, but digital pressure between the tip of the coccy, and the anus causes extreme, deep pain. In posterior levator and retrorectal space abscesses, the circumscribed bulge of the abscess into the rectum is readily palpated in the posterior midline. Bidigital examination often reveals the abscess to be under marked tension and protruding into the rectum, like a large walnut. Frequently, it is

most difficult to be absolutely certain as to whether one, or both, of these spaces is involved When this problem arises, the question is kettled When the retrorectal at the time of operation space alone is involved, the bulging indurated area occurs above the level of the levator muscle and extends for several inches up into the pelvis between the rectum and the sacrum In abscess of the posterior levator space, the bulge is usually smaller, about the size of a large walnut, and often under more tension than in retrorectal The bulge of the posterior levator space abscess overhes the smooth, rounded edge of the anorectal muscular ring (sling of the puborectalis When the lateral extension of the posterior levator space is involved (Fig. 1, 12, Fig. 3, 3) the bulge of the abscess can be traced along the levator muscle to the corresponding position The medial boundary of the posterior levator space is formed by the combined longitudinal muscle layer of the rectum (Fig 3, 5, Fig 1, 7) Therefore, only a very thin layer of tissue separates the abscess cavity from the lumen of the rectum, namely, combined longitudinal muscle layer of the rectum, circular muscle layer, the submuscosa, and muscosa (Fig. 1, 2, 1) the fact that these abscesses tend to erode the rectal wall, I am of the opinion that upon many occasions in the past abscesses of the posterior levator and retrorectal spaces have been misdiag nosed as mural abscesses

Due to the larger size of the pelvirectal spaces and the elasticity of the peritoneum which forms their superior boundary, abscesses of these spaces are under less tension, are more fluctuant, and present a boggy sensation to the index finger. The bulge of these abscesses hes above the level of the levator muscle

In the more complicated cases, all the peri-anorectal spaces, both superficial and deep, may be involved due to (1) simultaneous formation of abscesses in the different spaces, (2) in long-standing cases to separate involvement of the spaces along their individual pathways of infection, and (3) to rupture from one anatomic space into another

In making a diagnosis, one must always take into consideration the other coexistent painful anorectal lesions found upon examination, such as anal fissure and ulcer, thrombosed, prolapsed, strangulated, or gangrenous hemorrhoids, prolapsing anal papillae and ischioanal abscess, and evaluate their importance. Too often the examining physician concludes that this lesion is the only cause of the patient's discomfort.

#### Treatment

Once the diagnosis of perirectal abscess is made, no time should be lost before operation. These deep abscesses, with their inevitable fistulas, are

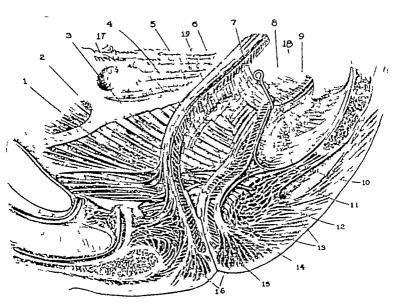


Fig. 3 Midsagntal section somewhat schematic showing the relationships of the anorectum to the pelice displaragm and the anorectal musculature. A window has been cut through the lateral wall of the rectum, layer by layer to show the relationships lateral to the rectum. (Disection by author)

- 1 Combined longitudinal muscle layer (anterior to the rectum) This layer is composed of the longitudinal muscle layer of the rectum, fibers from the levator fascia and fibers from both the superior and inferior layers of the levator.
  - # Inferior layer of the puborectalls muscle.
- 5 Arrow lying in the posterior levator space. This space surrounds the rectum like a horseshoo, with the open end of the horseshoo toward the publis
  - 4 Superior layer of the levator muscle
  - 5 Combined longitudinal muscle layer of the rectum (posterior to the rectum)
  - 8 Fiber from the superior layer of the levator to the combined longitudinal muscle layer of the rectum
- 7 Inferior boundary of the posterior levator space formed behind the rectum by the superior surface of the cocyygeal muscular raphe.
- 8 Hierectococygeus muscle formed by fibers from the lilococy gous (atriped) fibers from the longitudinal muscle layer of the rectum (amouth) and a few fibers from the levator fascia. This muscle forms the superior boundary of the posterior levator space behind the rectum.
  - 9 Retrorectal space.
  - 10 Coccygeal muscular raphe—attaching to the tip and sides of the coccyx.
  - 11 Posterior subsphinetone space (connecting the two ischioanal fossae)
  - 18 Puborectalis muscle (the sling of the puborectalis behind the rectum)
- 13 Fibers of the deep external anal sphincter muscle inserting into the skin along the anococcygeal skin sulcus.
  - 14 Deep external anal sphincter muscle (posterior to the rectum)
  - 15 Anal intermuscular septum.
  - 16 Subcutaneous external anal sphinoter muscle.
  - 17 Obturator fascia.
  - 18 Rectal stalk.
- 19 Anatomic tract lying within the combined longitudinal muscle layer of the rectum, extending from the circumanal space (level of the anal intermuscular septum) below to the fessules in the retrorectal space above

best operated in stages. The first stage should include incision and drainage and the location of the primary crypt and tract through which the infection originated

Transsacral caudal block is the first choice for anesthesia, and low spinal the second verted, or "lack-kmfe" position, offers many advantages over all others for these operations abscess and fistula operations the anorectum should never be dilated because of the possibility of spreading the infection or rupturing the fistu-Such a rupture makes it more diffilous tract cult to follow the entire tract throughout its If the anorectal line is carefully incourse spected, occasionally a drop of pus may be seen exiding from the offending crypt, otherwise, every crypt must be explored with a fine silver were crypt hook to determine, if possible, the location of the primary opening When an anal ulcer is present, there is usually little difficulty in inserting either a crypt hook or ball-pointed grooved director along the primary tract into the abscess cavity However, extreme gentleness must govern this procedure, otherwise, the probe may be forced through the wall of the fistulous tract and a false opening created Only one or two minutes are necessary for the exploration of If the primary opening is not readily the crypts found, the surgeon should proceed with the operation and depend upon locating the primary opening from the abscess cavity after incision and A bidigital examination performed at this time often adds more information as to the extent and location of the abscess

It is better to open these deep abscesses under direct vision, layer by layer, to be absolutely certain of landmarks

Posterior levator and retrorectal space abscesses are best opened and explored through a This separates, rather posterior midline incision than severs, the fibers of the external sphincter. the coccygeal muscular raphe, and the illorectococcygeus muscle (Fig 3, 13, 10, 8) places the anal end of the incision in close proximity to the usual posterior location of the primary opening The abscess cavity is gently explored with the finger for size, pockets and openings extending into adjacent spaces should not be used in breaking up pockets, and if the abscess is walled off, under no circumstances should this protective barrier be ruptured. The incision is extended from the anorectal wall to the tap of the coccyx If the lateral extension of the posterior levator space or the pelvirectal spaces are involved, a curvilinear counterdrainage incision is made lateral to the external sphincter This incision is carried anteriorly to the muscle full extent of the abscess cavity and postenorly to the lateral margin of the posterior insertion of the

external sphincter into the skin (which should not be cut) After passing through the fat of the ischioanal fossa, the inferior layer of the levator muscle, covered by the anal fascia, is identified and incised, thereby opening the lateral extension of the posterior levator space If the pelvirectal space is involved, the superior layer of the levator also must be incised. If a crypt or anal ulcer, which the surgeon suspects of being the primary opening, has been located, he should attempt again to pass the flexible probe or ball-pointed grooved director from this opening into the abscess cavity, placing his index finger into the abscess as a guide If he is unsuccessful, he should reverse the procedure, attempting to locate the primary tract from the abscess cavity Once the primary tract is found, a heavy silk seton should be drawn through it and tied loosely around the intervening sphincter musculature edges should be trimmed far back to prevent inversion Several Penrose drains should be passed into the abscess cavity, and one or two more passed from the primary through the counter drainage incision, and fastened

Penicilin and appropriate sulfa drugs are prescribed, both before and after operation

The Penrose drains are removed in twenty-four to forty-eight hours. The wounds are kept open, and bridging prevented, by gently drawing a sterile gloved finger along the base of each wound at three- to five-day intervals. This is continued until complete healing has occurred. All dressings are removed on the morning following operation, and continuous hot boric compresses applied. Hot sitz baths are instituted as soon as the drains are removed and are continued four times daily. The patient is permitted bathroom privileges eight to twelve hours following operation.

The second stage of the operation, or fistulectomy, is not performed until the wounds from the previous operation have healed up to the seton which was inserted at the first operation

The cardinal principle of fistula surgery demands that the fistulous tracts must be opened from their primary source to their termination, regardless of how much muscle intervenes. Since it is equally important to have a continent patient, there are certain other principles which must be observed. The surgeon cannot cut through the entire anorectal musculature in one stage without permanent loss of sphincter control. However, continence can be maintained throughout the entire convalescence if the intervening musculature is incised in two stages.

In those cases in which a seton has been left in place, a flexible silver wire probe is passed along the side of the seton, one end protruding from the unhealed portion of the wound and the other end brought out through the anal opening, and the ends loosely twisted together. This bends the probe like a hairpin and brings each portion of it in close apposition to the bowel wall. Starting internally, the surgeon cuts through the bowel wall from cephalad-caudad until the innermost edge of the subcutaneous sphincter is reached, using both limbs of the probe as a guide. A seton is tied loosely around the subcutaneous portion of the external sphincter, to be cut out at a later date No packing is placed in the wounds. Healing is controlled from within outward, by keeping the distal portion of the wound open with the gloved finger As soon as the wound has healed up to the seton, the subcutaneous sphineter is incised, the tract lightly curretted, and the primary opening and all other coexistent anorectal pathology (crypts, papillae, and hemorrhoids) excreed.

The roof or superior boundary of the posterior levator space is formed by the iliorectococcygeus muscle (Fig. 2, 8, Fig 3, 8) Therefore, if the surgeon completely lays open the tract to this space, only the illorectococcygeus portion of the levator will be left intact. Even though this portion of the musculature is enough to maintain continence, it is far better to split the musculature in two stages. When the retrorectal space is involved (Fig. 3,  $\theta$ ), it becomes necessary to divide the entire anorectal muscular ring, therefore this procedure must be performed in stages. The primary tracts to the priving tall space (Fig. 1, G, J) should be removed from within the lumen of the bowel at the time of fistulectomy volves incising the mucosa, submucosa, internal sphincter, and a portion of the combined long-It leaves the tudinal muscle layer of the rectum entire subcutaneous, deep sphincter and anorectal muscular ring intact, and is a relatively simple procedure. Severing of the internal sphincter is of little importance, as far as "bowel control" is concerned. When a supralevator abscess has ruptured back into the rectum, thereby forming a high secondary opening (true analrectal fistula (Fig 1, M), making it necessary to sever the entire ancrectal musculature, this procedure must be performed in stages.

On many occasions, during the operation, open ings will be seen in the location of normal anatomic pathways, and the surgeon is unable to tell at the moment, whether or not they are pathologically involved. Frequently by inserting a sharp-pointed hemostat into the opening and spreading it, or increang it one-fourth inch, he is immediately able to tell if granulation tissue is present

In chronic fistules involving the perirectal spaces, there are often one or more secondary openings upon the perianal skin, the result of previous rupture or inclaional drainage of the abacesa. If the entire course of the fistula is not known, it is unwise to start the fistulectomy from the primary or internal opening, which immediately involves severing the anorectal musculature. In these extensive cases, the fistulous tract should be exeased from the secondary skin opening down to the anorectal musculature and a seton inserted, as previously stated

#### Conclusion

Surgery involving the perirectal spaces is defi nitely major surgery There is no stereotyped, surgical procedure which can be followed operation must be fitted to each individual patient, not the patient to the operation The time spent searching for elusive pathways of infection is by no means wasted. The surgeon who prides himself upon the speed with which he can perform these operations will certainly have a much higher percentage of failures than the surgeon who is careful and meticulous in his anatomic dissection

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#### Discussion

Dr A. W Martin Marino Brooklyn New York -I am in complete accord with the essaylst s statement that operations involving the perirectal spaces are definitely major surgery Important pelvic structures are involved and abscesses in these regions if neglected, will endanger life. If the surgeon bears in mind and recognizes the pathways of infection to the spaces under consideration, operations for these deep abscesses need not be technically difficult and satisfactory results can be anticipated.

The speaker emphasized early diagnosis and immediate operation in these cases. The diagnosis should be made in 100 per cent of the cases by simple digital examination and, unlike abscesses elsewhere in the body, perirectal abscesses should be drained properly as soon as possible after the diagnosis is made. Waiting for fluctuation, pointing localiza tion and so on is a waste of valuable time I have seen patients who have been suffering for days with roctal pain, fever inability to eat, dehydration, and prostration while their physicians were waiting for visible signs of local infection to develop The diagnosis can be made promptly with the examining Unless the diagnosis is made early these deep abscesses will extend from one space to another until eventually all the spaces may become involved. Extension of the infection ceases as soon as adequate drainage is established.

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# CLINICAL EVALUATION, TREATMENT, AND FOLLOW-UP OF M. ACQUIRED TUBERCULOUS LESIONS

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(From the Grasslands Hospital)

CONTINUOUS tuberculosis case finding A program, which consists of pre-employment and subsequent routine chest \-ray films of employees at Grasslands Hospital previously reported, has provided the opportunity for observing newly acquired tuberculous lesions in the various stages of development, progression, or regression Each of the 67 employees reported here out of 6,869 employees covering a period from January 1, 1932, to January 1, 1947, had one or more negative chest \-ray films and was without symptoms prior to the development of disease

A record of the tuberculin reaction in this series, complete since 1942, was available for only 50 per cent of patients prior to that time lesions described developed in persons during a period of employment at Grasslands or affiliated hospitals and all but 11 who developed disease were known to have had exposure, and the others the opportunity for direct or indirect contact

Annual follow-up, in most instances by the hospital staff, was obtained on all but one person who was lost track of in 1936 She was a graduate nurse with a minimal lesion classified as arrested when last examined

Table 1, Section A, shows the number of newly acquired lesions for each of the years beginning 1932 through 1946, and the classification mal lesions, pleural effusions, and mediastinal node involvement constitute 82 per cent of the lesions observed, while 11 had reached a moderately advanced and 1 a far advanced stage when detected, and account for 18 per cent

Original pulmonary lesions developed in the right lung 35 times, in the left lung 19 times, and bilaterally 3 times Four effusions were on the right and four on the left side node enlargement protruded bilaterally in each Mediastinal

Since all lesions developed over a period of a few months they were considered to have elements of an exudative character and, therefore, to be active However, some appeared strikingly productive or fibrotic on the roentgenogram when

Table 2 shows the age groups, sex distribution, and occupation of employees Since there were slightly more than twice the number of women

Presented before the Medical Society of the County of Westchester, White Plains, New York, January 21, 1947

than men employed in the group, the par does not appear to be significant. In' the higher incidence of disease occurred a under 30 years of age

All but 5 patients were admitted the Tuberculosis Division and reof ten and four tenths months of ' ~ ' including an average of six months bed is out bathroom or other privileges in form of ambulation, except for weekly While on bed rest patients at IMBLE 2-In: a takınc ported to and from treatment nous the 1-ray department on stretchers Rx-ray films were taken of patients too lit transported to the x-ray department

Five not treated at Grasslands gave up followed a routine of cure elsewhere, and for the most part, followed by the ...

Twelve patients had advanced , by In addition, In lesions when first detected minimal lesions progressed to an advanced! as shown in Table 1, Section B Five > from the time of detection and while on bel and 5 reactivated and progressed after fix sponding favorably to a period of ha and bed rest

All advanced lesions were accompanied symptoms and abnormal physical signs, and duced a positive sputum In addition to be a 7 patients received pneumothoray, 4 bilities and 3 of the 7 subsequently required inplasty

Thirty-five employees with minimal pri ary tuberculous lesions received bed rest and Three with m portive treatment only lesions required two or more periods of bed but did not advance Two are now reco Eighteen of the 35 had initial treatment symptoms which often were taken lightly by individual, although occasionally they men sufficient severity to cause concern, and ass sult medical advice was sought before no check-up was due Seventeen had no read symptoms

Eight employees who developed pleurs in effusion had the usual symptoms In 3 thether fluid was positive for tubercle bacilli on gur The fluid was reported us pig inoculation Four of the 8 develop for tubercle bacıllı ın 5 The pleural fluid was po tive for tubercle bacilli in 2 cases and negaling pulmonary lesions

Are Groups

N to 25 years 75 to 30 years 10 to 35 years 15 to 40 years Over 40 years Totals 4 All 7 were 19 3

M) Seats\*

2. Two lessons efingon and 2. these patients t ally negative nediastinal

> asthma, in acromegalic f ulle cases, and by of the land ententis

Coexisting T

plicated by Table 1, " employees consider . teen are relapse of ... receiving arrested

> The pro minimal, advanced recovered, covered the four,

track of in

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TABLE 1

		CLASSIFICATION OF NEWLY ADQUISED LESIONS Moder			Brown Brown	Pro- Follow up					activated Lesions				
	Cotal	Min- imal	Ad Vanoed	Far Ad- vanced	Pleural Effu- sions	setinal	to Ad vanced Disease	Well- Able to Work		No Con- tact	Died	Well— Able to Work			Tot
	0 6	5	1			1	2	3		1		1 2	1		6
-	3	3	1		1	1	,	1				1	Q	1	2
-	Š	9 8	-1	1	1		•	3	ı		1		1		3
c	54	2	1		2 1		1	1			1	1	_		Š
-	10	8	1		1		2	3 7	3		1	1	1		6 4 10
7	67	45	11	<u>i</u>	8	2	10	42	4	1	8	7	9	1	67

22 E 2 - Distribution of Age, Sex and Occupation of Employees Who Developed Dissage, January 1 1932 to January 1 1947

f	Phy	eiclans	Bt	udent Vu	Gr	aduate	Atte	ndante		ther ployees		Cotal	
g Groups 120 years* 25 years 30 years 35 years 40 years 40 years	Men	Wome 1 1	λľen 1	Women 6 13 2	Men 1	Women 11 4	λlen 1	Women 1 2 1	Men 1 1 2 1 1	Women 1 3 1	3len 4 8 4 3 1	7 27 10 3	Total 7 31 18 7 2
rtals	11	2	1	21	1	15	1	4	6	5	20	47	G

IAII 7 were 19 years of age.

th Two lesions developed on the same side as the side and 2 on the control ateral side. In 3 of sepatients the tuberculin reaction was originary negative and in 1 it was positive. Two had a diagrams and one involvement.

### Sexisting Diseases and Complications

Tuberculess developed in 1 employee with hma, in another with diabetes, and in 1 with romegalic features Pulmonary tuberculosis somplicated by tuberculous laryngits in 3 ses, and by tuberculous enterits in 3 cases, 2 the latter having coemistent laryngits and dentis. Pneumothorax treatment was comleated by empyema in 2 cases.

Table 1, Section O, shows the present status of nployees Forty nine are classified as well and mader themselves fully rehabilitated Thir sen are now curing 4 for the first time and 9 for slapes of disease Four of the latter group are serving pneumothorax and 1 of these has had a horacoplasty on the contralateral side. One, an treated case of minimal tuberculesis, was lost rack of in 1938 4 died

The present classification of the leasons is 36 unimal, 13 moderately advanced, and 8 far dvanced. Four patients with pleural effusion ecovered, and 2 with tuberculous adenitis reovered Tuberculous was the cause of three of he four deaths.

#### Deaths\*

A 31 year-old asthmatic patient with a minimal lesion who had transferred to the West to continue her cure died of "heart disease." She possibly had cor pulmonale as the electrocardiogram showed signs of right heart strain while she was at Grasslands Hospital

One death resulted from progressive bilateral bronchogenic tuberculosis in the case of a nurse who was unable to adjust to hospital routine and attempted to take the cure at home.

The two hospital deaths resulted from progressive hematogenous tuberculosis.

Case 1 -8. A. a 21 year-old white woman, a student nurse entered the Westchester School of Nursing on September 1, 1938. The family history was negative. Serial roentgenograms were nega tive from the time of admission until March 1941 Her assignment in the Tuberculosis Division was in February and March of 1941 and she stated that she had contact with tuberculous patients in other parts of the hospital. On March 19 1941 she became hoarse and lost her voice. Her temperature was 101 F and an x ray of March 30 revealed an exudative lesion in the right second anterior inter space. Her tuberculin reaction, which was negative through 1 mg, of old tuberculin on March 13 1941 was positive to 1/100 mg. of old tuberculin on April 10 1941

Case histories of the 2 cases that died in the bospital are given here in detail.

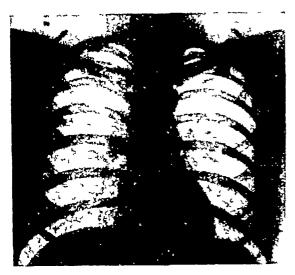


Fig 1 (Case 1) Reveals early exudative lesion, right second anterior interspace

Physical examination and laboratory findings were essentially negative except for evidence of laryngitis and positive gastric culture for tubercle bacilli. She was placed on strict bed rest and supportive treatment. Her course was progressively downhill, with increasing involvement of the laryna, and x-ray evidence of intestinal involvement. Roentgenograms revealed progressive bilateral dissemination suggestive of a hematogenous type, although the early lesion was exudative and cavitated. She expired on July 24, 1944, after forty months of hospitalization. There were no signs of meningitis

Case 2—K J, a 19-year-old white woman, a cadet nurse, entered the Westchester School of Nursing in January, 1944 The family history was negative Serial chest roentgenograms were negative

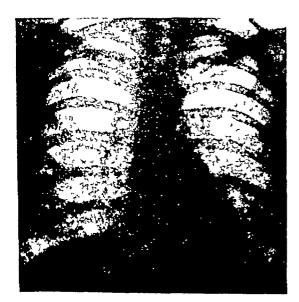


Fig 2 (Case 1) Reveals subsequent pulmonary homatogenous (?) dissemination

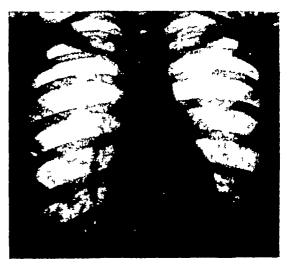


Fig 3 (Case 2) Negative film on June 12, 1945

until August, 1945 She completed a six-week assignment in the Tuberculosis Division in July, 1945 Her tuberculin reaction, which was negative through 1 mg of old tuberculin on March 5, 1945, was positive to 1/100 mg of old tuberculin on August 13, 1945 On August 20 she developed enlarged cervical glands bilaterally, accompanied by fever On September 12 an x-ray of the chest revealed widely disseminated pulmonary hematogenous seeding, and her sputum was positive on culture A mass of cervical nodes bilaterally measured approximately 6 by 8 cm Auscultation revealed scattered fine crepitations throughout her lungs Early in October she developed pain in the right ear and examination revealed a bulging drum which subsequently perforated and proved to be tuberculous. Early in

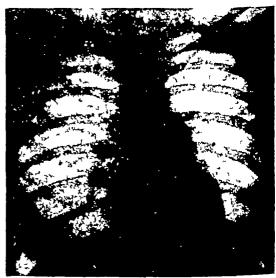


Fig 4 (Case 2) Reveals widespread biliteral involvement, hematogenous type September 14,

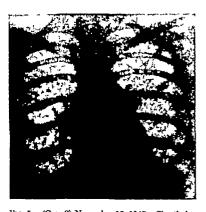


Fig 5 (Case 2) November 15 1945 Shortly before death.

November she developed hearseness, less of voice and examination of her larnyx revealed extensive ulceration of the vocal cords. This extended very rapidly involving the nasopharynx. Her course was rapidly downhill and she expired on November 29 after seventy-eight days of treatment. There were no signs of meningitis.

#### Clinical Evaluation

Amberson considers early pulmonary infiltrates in young adults to be potentially active and progressive until proved otherwise . Our experience amply confirms this observation The explosive nature of apparently innocent pulmonary lesions has been emphasized recently by Muschenheim,3 and this experience also supports his observa-Twelve lessons in this series were advanced when first detected and 10 patients with minimal lesions developed advanced disease and 4 patients with pleural effusion subsequently developed pulmonary disease. All of these were accompanied by symptoms and x ray evidence of activity Five of the 10 minimal lesions that advanced were positive on culture or guinea pig inoculation of sputum or gastric washings before advancing. Cultural technics now employed reveal a high percentage of positive cultures of gastric washings in early minimal lesions. Ord way, Medlar, and Sasano have shown that repeated cultures often reveal acid-fast organisms of gastric washings even after clinical stabilisation of the disease has occurred

Other laboratory data in this series were not particularly helpful from the standpoint of prognosis, although the sedimentation rate, lymphocytic, and monocytic counts were higher in advancing lesions These were routine examinations and were not planned or done as a special prognostic guide

Lesions that developed in negative tuberculin reactors had a tendency to show less stability than those in positive reactors. Seven of the 9 relapses occurred in this group and received an average of thirteen and nine tenths months' hospitalization at Grasslands, and 4 of them are still curing

#### Treatment

All newly acquired lesions were considered active and, therefore, to be in need of prompt hospitalization and treatment. Those that were hospitalized received bed rest in addition to special collapse procedures as indicated The indica tions for bed rest in the treatment of tuberculosis are so widely accepted that they do not need further discussion here. It may be said that no ill effects from bed rest were encountered in this The value of collapse therapy is demonstrated here again where pneumothorax and thora coplasty were required to arrest the progress of the disease. The principles of collapse procedures are generally accepted and need no elaboration at this time Practically all services of the hospital were called upon to assist in the management of this group of patients with tuberculous, its complications, or other coexisting disease. There is no purpose in discussing the various technics of treatment since they are familiar to all of you.

Streptomycin was not available for this group, but if rapidly progressive hematogenous or millary forms of the disease and meningitis should be encountered in the future, its use would seem justified in view of the experience reported by Feldman and Hinshaw <sup>5</sup>

Follow-up—As shown in Table 1, Section C, 49 of the 67 patients are well and working or able to work. Contact was lost with 1 minimal arrested case. Thirteen are still curing and 4 have died Of the 13 that are curing the prognosis is favorable in all except 1 case of bronchial disease this patient is ambulant

#### Preventive Technics

More important than treatment is prevention. Tuberculoses in recent years has often been regarded as an occupational hazard for hospital workers especially for those in close contact with the disease. This has served to create undue fear among certain groups of the public and the profession. This is not surprising since nearly every compensation claim is supported by medical authority for and against the validity of the claimant. The cost of compensation is one reason why nursing schools are not permitting their

students to affiliate in tuberculosis It is not reasonable to expect that physicians and nurses will go through life without tuberculosis contact, and, moreover, one does not enter the fields of medicine and nursing to evade responsibility There is no more justification for refusing to care for tuberculous patients on these grounds than there is for refusing to care for other infectious or contagious diseases Instead of emphasizing the danger to tuberculosis exposure it is well to point out that approximately 985 per cent of those intimately exposed do not develop the disease Attention to inherent or acquired mechanism of protection is worthy of more attention

Applying the Modified Life Table formula used by Frost,6 the annual attack rate for nurses in this series, as reflected in Tables 3 and 4, was student nurses 1 39, and graduate nurses 0 99 per 100, respectively Riggins and Amberson<sup>7</sup> reported a morbidity rate of 1 93 per 100 for student nurses at Bellevue Hospital, and Beckerman,8 in a similar study, reports 122 latter figures, as well as our own, are considerably higher than those reported by Muschenheim, Bunn, and Lansdown which were medical students 0 2, student nurses 5.2, and graduate nurses 60 new cases per 1,000 per year for students at New York Hospital 3 It is also higher than reported for comparable age groups reported by Reid for clerical employees in the Metropolitan Life Insurance Company, which was 2 to 3 per 1,000 per year D M Lim-Yuen, using the same formula, reports an annual attack rate of 18 per 100 for sanatorium employees at Manitoba Sanatorium 10 Myers, Diehl, Boynton and Trach<sup>11</sup> report an overwhelming preponderance of lesions in medical and nursing students in a student body of approximately 12,000

TABLE 3 -STUDENT AND AFFILIATING NURSES

Year 1932 1933 1934 1935 1937 1938 1941 1942 1944 1944 1945	Num- ber Present at Begin- ning of Year 1x 27 31 29 35 39 42 34 43 55 64 68 66	Number Added During Year Nx 34 47 53 76 83 76 65 52 63 61 60 52 24	Number Leaving Dur- ing Vear Wx 34 33 52 47 43 63 63 63 63 43 54	Mean Number Present During Year Lz 57 68 90 86 86 104 164 170 5 49 107 5 111 5 52	Number Developing Active Tubers of T	Attack Rate Per 100 0 0 0 0 2 1 16 0 0 0 1 92 0 6 0 5 0 62 1 8 0 7 1 7 0 0 15 3
	tals			1,577	22	1 5

Search for unsuspected tuberculosis in the general wards and intensification of protective technics have become a part of the routine at Following a demonstration begun Grasslands in July, 1941, chest roentgenograms have been taken on admissions to the general hospital wards 12 When tuberculosis is discovered patients are promptly placed on barrier and transferred to the Tuberculosis Division In the Tuberculosis Division protective measures consist of wearing masks and gowns and frequent washing of hands by those in close contact with patients This has been a rigid requirement of student nurses and interns with a negative tuberculin Sicker patients are isolated in indireaction vidual rooms Collection of sputum and other specimens is carefully carried out, and employees in close contact with tuberculous patients receive chest roentgenograms at six-month intervals or Hygienic living habits, rest, and proper less nutrition are encouraged An educational program in protective technics for hospital workers and patients is a necessary part of any wellplanned hospital program

In regard to infection, it is interesting that 18 student nurses converted from tuberculin negative to tuberculin positive before they were assigned to duty in the Tuberculosis Division Since there was thought to be little danger from exposure to the general hospital patients who were screened on admission, it was necessary to look elsewhere for possible contact. In doing so it was found that all of them had been in contact with a considerable number of tuberculosis patients treated in other stations in the general hospital

In Table 1, Section A, it will be seen that the higher morbidity occurred in 1945, after case

TABLE 4 —GRADUATE NURSES

	IABLE 4 GRADUATE NURSES									
Year x 1932 1933 1934 1935 1936 1937 1938 1939 1940 1942 1944 1945 1946	Number Present at Beginning of Year Ix 90 108 107 107 107 104 122 140 135 123 110 97 74 88 90	Num- ber Added Dur- ing Year Nx 45 32 34 20 66 67 36 42 54 35 11 93 84 61	Num- ber Leav- ing Year Wx 27 33 424 24 24 54 48 49 41 54 48 34 67 82 62	Mean Num- ber Present During Year Ls 99 107 5 108 106 5 113 137 5 129 116 5 103 5 85 5 81 89 89 5	Number Developing Active Tubers During Year ds 0 4 2 0 0 1 1 0 0 2 1 1 1 1 0 0 0 0 0 0 0 0	Attack Rate Per 100 ms 0 0 0 3 7 1 9 0 0 7 1 4 0 1 7 0 1 1 2 1 0 0				
Tot	815			1 603 8	16	0.88				

finding measures had been sharply intensified. We believe, however, that this may be due at least in part to adverse living conditions and poor food as a result of the war

I concur in the opinion expressed by Muschenherm that to impose a strict isolation technic of the kind employed for highly contagious diseases is impracticable if not misleading. As shown by this experience with tuberculin conversion, until other stations in the hospital have been freed of tuberculosis, instituting an isolation technic in the tuberculous division will not necessarily prevent exposure At the University of Michigan Hospitals, Barnwell found that of 26 student nurses, 4 who developed the disease originally had a negative tuberculin reaction and were exposed to 5 cases of open tuberculosis in the gen eral wards 13 Only 2 of these were exposed in the tuberculosis wards for a period of one month where they were required to follow a protective technic

Discussion of preventive measures would be incomplete without reference to renewed interest in BCG vaccine generally, and especially for selected groups of individuals. Holm states there is no doubt that vaccination protects against primary tuberculous infection but is less sure that it protects against pulmonary tuber culous or phthisis." Much experience has accumulated over the years, and Ferguson's experience in Canada is of special interest in relation to nurses.11 The reports of broader applica tion, especially in Denmark, by Holm,14 and in Indian Reservations by Aronson,16 and the work of Resenthal are all encouraging Therefore. the question rightly may be raised concerning its use in young tuberculin negative groups such as student nurses who are to be exposed

#### Summary and Conclusions

Sixty-seven employees out of 6 869, or 0 9 per cent. were treated for newly acquired tuberculous lesions during the years 1932 to 1947 The type extent, and classification of the lesions are discussed for the various age groups. The need for early diagnosis, isolation, and treatment is demon Treatment included bed rest and the selected use of collapse therapy Streptomycin was not available for this group, but is recommended for progressive hematogenous disease of the type described in the two deaths that occurred at the hospital The need for intensified protective technics is obvious, and BCG vaccination would seem to be indicated for young people with a negative tubercular reaction who are to be exposed

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#### DENTISTRY CAN PLAY IMPORTANT ROLE IN PREVENTING DEAFNESS

Many of the 10 million Americans who suffer with impaired hearing should be sent to a dentist, according to an article in the current issue of the Archives of Otolaryngology published by the American Medical Association. And, says the writer many fewer Americans would be so afflicted if more attention were paid to the role that intelligent dentistry can play in the prevention and control of deafness.

The writer David J Goodfriend, D.D.S of Phila delphis, is reporting on studies carried out in the department of dentistry medicine and psychology of the University of Pennsylvania Workers in this field, says Dr. Goodfriend, have established the importance of abnormalities of dental bite in producing certain hearing troubles "as thoroughly as Koch proved that the tubercle bacillus causes tuber Their studies point to dental treatment as culous. the proper therapy
Anatomic studies show that any abnormality of

dental bite directly affects the custachian tube which brings about communication between the middle ear and the pharynx by adjusting air pres-sure in the middle ear to that of the air outside. Dr Goodfriend s article does not claim that some such condition is at the root of every hearing defect nor that the one automatically brings about the other But it does state that such abnormalities "probably influence about 40 per cent of all deafness.

Dr Goodfriend found that at the University's special car and throat clinic, 23 of the first 25 patients with hearing complaints but without any abnormalities in the ear itself showed abnormalities of bite or some position of the teeth which inter fered with proper movements of the jaw in chewing.

Studies of a group of 168 dental students showed that 55 per cent had dental malocclusions the bear ing of this group was 13 per cent less than that of the other 45 per cent.

# USEFUL PROCEDURES IN EARLY DIAGNOSIS OF LIVER DAMAGE FOLLOWING EXPOSURE TO THE CHLORINATED HYDROCARBONS

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# TETRACHLORETHANE, CHCl., 18 a color-CHCl.

less, volatile, noninflammable liquid with an odor resembling carbon tetrachloride. It is an extremely efficient solvent, but its toxic properties have prevented its widespread use in industry

During the first World War, Willcox in England investigated the cause of jaundice in 11 employees at the Hendon Aeroplane Factory 1 Gastrointestinal complaints and drowsiness were the chief symptoms Similar cases were found at Crayford and a seaplane factory Willcox exposed rats to the various constituents present in the "dope" used on the wings of the planes, and found that although acetone, benzene, and methylated spirits resulted in drowsiness, recovery was rapid upon removal from exposure and no abnormal findings were found at postmortem However, after a similar exposure to tetrachlorethane, fatty degeneration and cloudy swelling were present in the livers of the exposed rats Willcox concluded that tetrachlorethane was the toxic agent in the material used Further study showed that tetrachlorethane weight for weight was 2.8 times as toxic as chloroform

Because of its volatility (boiling point 146 F), inhalation is by far the most common means of intoxication, although toxic effects after absorption through the skin² and gastrointestinal tract have been reported

During World War II it was thought wise to impregnate all articles of clothing worn by the soldiers with a substance capable of neutralizing poisonous gases. No solvent for this substance was found that could compare in efficiency with tetrachlorethane. Hence, in spite of its toxicity, war necessity required the use of tetrachlorethane in the impregnating process.

The findings reported in this paper are based on experience obtained during the war years in a plant actively engaged in impregnating clothes and employing approximately 275 men and women.

Protection of the employees resolved itself into three main approaches first, engineering controls in the plant adequate to keep the amount of tetrachlorethane in the atmosphere at a safe concentration (most authorities agree that ten parts per million is the maximum safe concentration for

Presented at the 141st Annual Meeting of the Medical Society of the State of New York, Buffalo, Section on Industrial Medicine and Surgery, May 7, 1947 prolonged exposure), second, control of the employee through selection and supervision, and third, diagnosis of early intoxication so that further exposure, which may result in irreversible damage, can be prevented

The specific gravity of tetrachlorethane is 1 600-1 602. When cool the vapor will sink to the ground, but will rise on warming. Thus, the temperature of the gas is an important consideration in any plan for an adequate ventilation program.

In the process of impregnation with which this paper is concerned, the clothes, following impregnation, were chuted through a tunnel to drying Following the drying period the clothes were placed on tables for sorting The danger points, where maximum concentrations of the gas were found, were around the impregnating tanks, drying ovens, and the tables Exhaust funnels consequently were placed adjacent to the tanks and ovens and on the edges of the tables Careful consideration had to be given to the placing of the exhaust pipes outside the building so that the vapor would not be blown back into the Leaks and spills could not be avoided, so determinations of gas concentration in the working areas were performed at regular intervals

No ventilation system was found adequate to reduce the concentration of tetrachlorethane to safe levels immediately adjacent to the impregnating tanks or drying ovens. For this reason gas masks were provided for all employees engaged in work in these areas. Frequent testing of the masks and supervision to insure the wearing of the masks were necessary.

Applicants were selected for employment only after a careful history, physical examination, and laboratory study. Any disease or condition which might be augmented by tetrachlorethane exposure or which could lower the employees' resistance to exposure resulted automatically in exclusion. Applicants with a history of alcoholism or with evidence of previous disease of the liver, or of the gastrointestinal tract, the luetic under arsenic therapy, the anemic, those with kidney disease, and those pregnant were eliminated as poor risks.

Because of the protection against toxins afforded the liver by protein and carbohydrate, considerable emphasis was put on the dietary history of applicants for positions in the tetrachlorethane plant. It was found that much time was saved by having prospective employees fill out a

simple dictary form inducating their usual daily diet. On the basis of this form suggestions were made in their dictary habits.

The emotional stability of the applicant and his innate intelligence were found to be factors worthy of serious consideration. Each prospective employee was told the nature of his work and the hazard involved. The necessity for the utmost regard for such hygionic rules as wearing gauntiets when handling the chemical agents or contaminated materials, and a shower and change of clothes at the end of the shift was pointed out. Understanding the reason for these rules and a willingness to obey them was required of each applicant. A policy of frankness seemed to be appreciated by all employees and resulted in good comeration.

The sex and age of the applicant should be taken into consideration. In a study of the relationship of sex and age to incidence of intexaction, men appear to be less susceptible than women as judged by the fact that of 158 women employed 39 (24 per cent) showed evidence of intexication in contrast to 15 (12 per cent) of 119 men employees. Equally striking figures were evident in comparing the various age groups. Nine per cent of those 30 years or under showed evidence of intexication in contrast to 28 and 29 per cent in the older age groups (see Table 1) Thus, young men appear to be least susceptible to intexication following tetrachlorethane exposure

TABLE 1.—Incidence of Intoxication in Relation to

		-Age Group	
	30 Years		
	or Less	21-00 X cats	51-70 Years
Number with evi- dence of interies- tion	12 (9%)	\$3 (~9.97)	10 (25%)
Total number in age group	122	112	35

At the mitial history and physical examination a complete blood count, sedimentation rate, urn alysis, and Wassermann test were performed on all applicants in order to determine the presence of any disease otherwise not evident and because of which disease the applicant's health might be further impaired on exposure to tetrachlorethane.

The diagnosis of early intoxication was the third part of the program instituted in the impregnation plant. In spite of the excellent cooperation on the part of the supervisors and every effort to enforce the essential rules mentioned above, cases of intoxication developed. Occasionally such cases were discovered to be related to some unwise practice, yet many other cases occurred without any apparent reason other than continuous exposure for eight hours in a contaminated atmosphere.

Careful interval histories taken on 277 em ployees showed that 27 per cent acquired symptoms referable to the nervous system or the gastrointestanal tract or both. It is realized that such symptoms not infrequently occur in any group of people, however, the frequent association of these symptoms with other signs of in toxication, and their disappearance upon removal from the contaminated atmosphere suggested they should be given special consideration and further studies carried out. The employee was assured that another job would be available for him if removal from the impregnating plant was found necessary. This practice discouraged the concealment of symptoms.

As limited facilities prevented periodic examinations more often than once a month, a nurse inspected the workers at the plant each day and several times detected clinical jaundice unrecognized by the employee. Her immediate presence in a friendly informal atmosphere likewise encouraged the reporting of symptoms. In addition it was her duty to pay home visits to all employees absent from work because of illness. The doctor made a follow up visit if any of the symptoms or signs suggested tetrachlorethane intorication

The angle physical finding of the most importance, aside from clinical jaundice, was enlargement of the liver Of the 55 or 19 per cent of all employees who acquired enlarged livers, 26 or 47 per cent of this 55 had no associated symptoms whatsoever 4

Of the various laboratory procedures available for determination of liver function, the level of bile pigments in the blood, a rough quantitative estimation of the urobilinogen in the urine and the cephalin flocculation test seemed most practical. None required special preparation of the patient and a single collection of blood and urine was all that was required

Elevation of the bile pigments above normal but below the level of clinical jaundice occurred in 10 employees. The association of such a rise with liver enlargement or symptoms, or the return to normal of the bile pigment level after release from the plant, suggested such elevation was significant.

TABLE 2.—CEPHALIN FLOODULATION TEST PERFORMED ON

			_			
Total 232	Negative 194	14	+	++	+++ 1 Primary lucs	++++

The cephalm flocculation test proved to be of considerable assistance in furnishing additional ovidence of liver damage (Table 2) Of all cases showing definite evidence of liver damage only 3 had negative flocculation tests. Five machine

workers developed 3 or 4 plus flocculation tests without other symptoms or signs, suggesting that occasionally this test may be the first evidence of liver damage The relation of positive flocculation tests to hyperbilirubinemia was studied on 16 cases with definite evidence of liver involve-In 7 of these cases the flocculation test became negative before the bile pigment level returned to normal In 6 cases the flocculation test became negative at the same time that the bile pigments fell to a normal level In 3 cases the flocculation test remained positive after the bile pigments had returned to a normal level

The prothrombin time, sedimentation rate, and Takata-Ara tests were performed from time to time, but seemed to be of less value than the other

tests employed

### Summary and Conclusions

Tetrachlorethane is an extremely hazardous In spite of expert engineering advice and careful medical selection and control, symptoms suggesting intoxication appeared in 75, or 27 per cent, of 277 employees exposed to the fumes of this substance for an eight-hour working In addition 55, or 19 per cent, of the 277 employees acquired palpable livers Further, 8 employees showed elevation of bile pigments in the urine or blood without clinical jaundice or recognizable liver enlargement, and 4 acquired 3 or 4 plus cephalin flocculation tests without other symptoms or signs

These findings permit the following conclu-

sions

- Prolonged exposure to tetrachlorethane vapor, held for the most part within the permitted limits of concentration, will result in symptoms and signs of intoxication in certain employees Thus, the maximum "safe" concentration level should be revised downward
- Careful supervision of employees to assure obedience to hygienic rules and safety measures is An explanation to the employees of the nature of the hazard and the necessity for these safety measures was found helpful
- A careful initial history and physical examination with laboratory studies should be performed on all applicants in order to exclude those who are poor risks
- Frequent periodic examination must be performed on all employees Nervous or gastrointestinal symptoms may be the first manifestations of incipient intoxication Careful examinations for evidence of liver enlargement are necessary as this may be the first sign of intoxication Simple laboratory studies, such as determination of the level of bile pigments in the blood or urine, and the cephalin flocculation test were found very helpful both as diagnostic and prognostic procedures

537 DELAWARE AVENUE

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### A.M A. WILL HONOR GENERAL PRACTITIONER BY GOLD MEDAL

The Board of Trustees of the American Medical Association has established a special gold medal for a general practitioner who has rendered exceptional service to his community

The award, similar to the American Medical Association's Distinguished Service Medal which has been given annually since 1938 for scientific advancement in the field of medicine, will be given to a general practitioner for the first time at the supplemental session of the House of Delegates at Cleveland, Ohio,

on January 7, 1948

Designed especially for the physician who has served his people as a family doctor and who does not devote himself exclusively to a specialty in medione, the award will be known as "the medal of the American Medical Association for exceptional serv-

ice by a general practitioner"

Nominations for the award may be submitted to the headquarters office of the American Medical Association in Chicago by any state medical association or community service club, such as a Rotary, Kiwanis or Lions Club, Chamber of Commerce, woman's club, community council or similar group The nomination should include the name and address of the physician, his scholastic record, and a record of his medical service in the community

Nominations will be submitted to the executive committee of the Section on General Practice of Medicine of the American Medical Association, which is composed of Dr Wingate M Johnson, Winston-Salem, North Carolina, Dr Paul A Davis, Akron, Ohio, and Dr E A Royston, Los Angeles This committee will select five leading candidates for nomination for submission to the Board of Trustees, which, in turn, will nominate three of these to the House of Delegates

On the opening day's meeting at the supplemental session the House of Delegates will choose by ballot the general practitioner who will receive the

medal.

#### CERTAIN REASONS FOR FAILURE FOLLOWING DISK OPERATIONS

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(From the Department of Surgery Albany Medical College)

THE discovery of the role of the herniated intervertebral disk in the production of low back pain and sciatica, as well as the development of an operation for its correction, has aroused great interest in this syndrome. The clinical picture has been clarified and publicized considerably, with the result that the diagnosis of ruptured intervertebral disk is commonplace The splendid results reported by Dandy and Mixter soon popularized the operation, which is today performed with varying success by many surgeons While, on the whole, the results have been good, there have been so many exceptions that it is obviously time to pause, take stock and to discover, if we can how in one case we succeed when in an almost exactly similar situation we fail.

With this in mind we have restudied 106 patients operated upon by us in the Albany Hospital from 1937 through 1945, 122 of whom have returned recently for re-examination. Particular attention was given to the relief of pain, the increase or decrease of neurologic deficits, clinical and roentgenologic evidence of spinal fixation and muscle spasm, and finally, but of most importance, the patient's ability to return to his former occupation. This particular series consists entirely of patients who came to operation, but does not include the many believed to have had ruptured disks, who for one reason or another, were not operated upon

The results are summarized in Table 1 Sixtyeight patients were classed as "excellent," since
they were free from pain and had returned to
their former occupations, 33 were termed "good"
because they were doing lighter work without
pain or the same work with some discemfort,
and 21 were considered "poor" In this last
category were included all those who were, or
claimed to be, disabled because of continued
pain or weakness

# Factors Which May Influence the Type of Result

From a comparison of the three groups (Table 1) it appears that the average age and the preoperative duration of symptoms were not signicantly at variance in any Similar also was the
incidence of objective neurologic changes before
operation in the "excellent" and "good" groups,

TABLE 1

	Excel lent = 68	Good -	Poor =
Average age	39	39	40
Average preoperative dura-			
tion of symptoms, years	31/2	41/4	31/4
Preoperative neurologie		- , ,	- , .
changes	62	31	14
Preoperative orthopedic			
changes	66	31	19
Compensability	13	20	îĕ
Payehologio risk			
Good	35	16	4
Fetr	26	12	- i
Poor	7	-5	13
Disk level	•	-	
L581	39	16	8
LA—LS	26	17	16
13-14	-9	*;	15 2 5 6
Double disks	3 2 23	å	ž.
Sequestration	• • • • • • • • • • • • • • • • • • • •	2 7	ž
Poetoperative neurologic defi-	20	•	U
cit	44	30	14
Postoperative fixation	31	27	17
Increased postoperative disk	91		**
narrowing by x-ray (89)	16 (26)	5 (6)	5 (5)

whereas such changes were present in but twothirds of the "poor" group Spasm of the sacrespinalis muscles, flattening and limitation of motion of the lower lumbar spine and impaired straight leg raising were for sake of brevity termed "orthopedie" changes These were present in varying degree in most instances in all three groups. In this series therefore we have no evidence that any of these factors, save perhaps the lack of preoperative objective neurologic changes, played a part in the failures

Our experience, unlike that of some, has been that Workmen's Compensation plays a decidedly important role in many instances. Fig 1 shows in graphic form the comparative results of those with and without this form of insurance. It is evident, even in this small series, that those insured comprise a far less satisfactory group than those not insured. The fact that of the 21 "poor" results, 19 were "compensation cases" is striking particularly in view of the fact that in this series 70 of the 122 were not insured.

Psychologic Risk — Each patient was assessed by one of us and occasionally by a consulting neuropsychiatrist as to whether or not he was a good risk from the standpoint of his morale. These we divided into three classes "good," fair" and "poor" Particular attention was directed toward the patient's emotional stability his nervousness, his apparent ability to stand pain, his previous history of neurosis, and his degree of resentment, if any, toward his employer or insurance carrier. While the exactness of such an estimate, particularly by a surgeon untrained in the principles of psychiatry, is

Presented at the 141st Annual Mosting of the Medical Society of the State of New York, Buffalo, Section on Industrial Medicine and Surgery May 7 1947

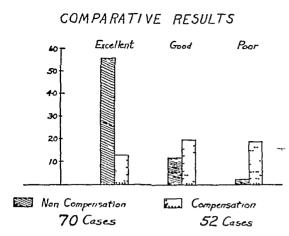


Fig 1

open to question, it would appear to be definitely significant that 13 of the 21 poor results occurred in individuals rated as "poor" psychologic risks

in individuals rated as "poor" psychologic risks

Influence of Disk Level—From this small series it is apparent that the proportion of "excellent" and "good" results were roughly the same whether the fourth or fifth disks were involved However, the fact that there were almost twice as many failures (as listed under "poor" results) at the L4—5 as at the L5 S1 level, suggests that the outlook may not be quite so favorable with the former disk

Type of Disk Pathology—In this study, the disk changes found at operation were considered under two headings First, protrusion with sequestration, and second, protrusion without sequestration In the "excellent" group 23 of the 68 were sequestrated, in the "good" group 7 of the 33, and in the "poor" 6 of the 21 were sequestrated. The actual number of cases falling into these three classifications is so small that percentage comparisons are not justifiable, however, it is evident that the proportions are so nearly the same that the slight differences are statistically insignificant.

### Postoperative Findings

Neurologic Defects —A study of the incidence of objective neurologic changes, such as absent or decreased knee or ankle jerks, areas of anesthesia or hypesthesia, and/or motor weakness, revealed, surprisingly enough, that, save for more severe degrees of motor weakness, these factors were not of overwhelming importance in determining the type of result obtained. Thus, 44 of the 68 "excellent" result cases, and 30 of the 33 "good" result cases presented postoperative neurologic changes which persisted for a year or more. Persistent pain or motor weakness of embarrassing degree caused us to classify any patient with this degree of disability.

among the "poor" group However, the persistent loss or decrease of a deep reflex or the presence of an area of anesthesia or hypesthesia by no means precludes an "excellent" or "good" result

Extradural Spinal Fluid Cysts—These, with demonstrable subarachnoidal communications, occurred after three of the earlier transdural operations. In each the pain came on soon after assuming the erect posture, coincident with which fluoroscopic myelography demonstrated contrast media entering the sac (Figs 2, 3). In 2 cases the fistula was successfully repaired at a second operation, while in another patient two attempts were unsuccessful and the result must be considered a failure.

Fixation of Lumbar Spine—This, with or without palpable spasm of the sacrospinalis muscles, was observed in the vast majority of the "poor" and "good" result cases, whereas it was present in less than half of those with "excellent" results. Thus it would appear that while a more or less rigid lumbar spine by no means precludes an "excellent" result, it is more often associated with a less favorable outcome

It would be helpful to know how much of the fixation was due to bony and/or ligamentous changes and how much to muscle spasm. At some future time, we hope to be able to present our experience in this regard

Increased Narrowing of the Disk—This was demonstrated, roentgenographically, in 26 of the



Fro 2 Lipiodol entering postoperative extradural arachnoidal cyst



Fig. 3 Myelogram showing postoperative arach noidal cyst (area of lessened density) and recurrent disk (filling defect)

39 patients from one to nine years after operation (Figs 4, 5) The remainder of the eases have not yet been re-examined in this fashion. The num ber in each category was thus too small to be of statistical importance. It is hoped that more data will be available soon.

#### Comment

On the basis of our experience we believe that accurate preoperative study and diagnosis, together with careful evaluation of the individual patient's morale are factors of such great importance that they hardly can be overemphasized In the selection of patients for operation it is well to remember the natural history of this disorder that periods of remissions characterize many cases, and that some of these may go for months or years with few or no symptoms. Many of the milder cases do not require operation and, indeed are just as well off without it Many will respond to conservative treatment, to some support to the back, and to the placing of bed boards under the mattress From a psychologic standpoint it is far better to operate when the patient is having an exacerbation of his pain and disability, rather than when he is in a remission. Furthermore it is unwise to promise or to assure any patient that he will have a perfect back after operation.

The clinical picture of a ruptured intervertebral disk is so commonplace, and in many instances the diagnosis is so obvious that one must be constantly on guard if the less common disorders producing low back pain and sciatica are not to be missed. Common among these are cauda equina tumors, such as neurofibromata, metastatic lesions, certain gynecologic conditions, esteoarthritis and hip disease. Just recently we studied a young woman who had been operated upon elsewhere with the diagnosis of a ruptured intervertebral disk, who was unrelleved of her pain, and who, when we saw her a few months later, presented an obvious esteosarcoma of the upper and of the femur.

#### Myelography

While in most instances the diagnosis of a ruptured disk may be made with reasonable assurance without the aid of contrast media, myelography can now be done with such ease and harmlessness that we have carried it out almost routinely. In many of the earlier cases lipiodol was used. Much controversy, now academic, has taken place concerning this agent. Since it has been available pantopaque has been utilized because of its superior delineation of defects and the greater ease of its removal. While the procedure of myelography is not diagnostically infallible it does give one assurance in most



Fig. 4 Roentgenogram of lumbar spine showing preoperative narrowing of lumbosacral disk.



Fig 5 Roentgenogram of lumbar spine showing increased narrowing of lumbosacral disk six years after operation

instances as to the existence and the location of the disk. It is true that we have found ruptured disks in some patients who had apparently normal myelograms and vice versa, and have occasionally not found protrusions in some who were thus diagnosed by myelogram. By and large the procedure has been well worth while. Furthermore, certain double disks (particularly if the unsuspected second one is contralaterally situated), certain tumors, and a few completely sequestrated bits of disk tissue, which have slipped either well above or well below the disk level, might have been missed without its use

### Summary and Conclusions

A series of 122 patients operated upon one to nine years ago for removal of a ruptured intervertebral disk were personally restudied. Based upon absence of pain and ability to return to original work, 68 were classified as having obtained "excellent" results. Twenty-one patients were termed "poor" result cases since they had not returned to work and since they complained either of pain or of motor weakness which prevented their resuming their usual activities. It is of interest, and apparently of significance, that 19 of this group of 21 came under Workmen's Compensation, while 13 were considered before operation to be poor psychologic risks. In some cases, however, the reasons for failure were per-

sistent neurologic defects, such as motor weakness and obvious pain. It is believed that at least three or four of this group have recurrences, but they have refused further procedures thus far. It is noteworthy that certain persistent postoperative neurologic defects, such as absent or diminished knee or ankle jerks, or persistent areas of hypesthesia or even anesthesia, do not necessarily preclude an "excellent" or "good" result

If the patient has had bilateral sciatica we believe that it is worth while exploring the disk on both sides of the spinous process, since, in our experience, it has sometimes been impossible to decompress the opposite root from one side satis-We also believe that one should operfactorily ate only on those individuals who cannot get along with conservative treatment, and if operation be performed, that it be carried out at a time when the patient is having pain or disability, rather than when he is in a remission Furthermore, it is of great importance to reserve operation for those individuals who are in very real pain, who are disabled and who are anxious both to get well and to work again

### Discussion

Dr Howard L Prince, Rochester, New York—This interesting paper is of a type much needed by the profession at large. One of the legitimate criticisms of surgeons is the tendency of all to start doing some type of operation long before the originators have discovered the difficulties. Another of our faults is the often delayed reports of these difficulties by the originators. Then, too, the parent of an idea is likely to be no more trustworthy in his evaluation of its virtues than the parent of a physical child. One must ask the neighbors or relatives.

I have been wandering in the maze of "The Back Problem" for about thirty-five years now and feel that, while perhaps I really know more about it now, I know that I am not so sure of it as years ago first came under the impress of Joel Goldthwaite. In former days, if the pain was limited to the low back it was lumbosacral strain If the sciatic distribution bothered, it was sacroiliac distortion. One read the x-rays and, if from Boston, manipulated accordingly, but if from Hopkins and Baer, all were manipulated the same True, we did obtain some astonishing results, but the failures piled up arrived the idea of fusing the sacroiliac or the lumbosacral regions and, not infrequently, one after the Here again we had good results, and by the time we learned that many of the results did not last we had left a train of operative scars across the country The Canadian neighbors always remained rather skeptical, especially of sacroiliac diagnosis and operation Along with the operative successes there continued a lot of failures But failures easily pass into oblivion or other doctor's hands, some wearing the belts and/or backbraces we have applied after operation and getting along with the feeling that their back pain is a cross they have to

bear and make the best of And always the compensation insurance companies were finding that they were carrying a very high percentage of failures.

Then came the very careful work of Mixter and his follows with its great promise of relief for some cases carefully chosen with cooperation of surgeon, radiologist and neurologist. Long before any prolonged or intensive study of results could be made disk operations became common, their confidence and danger enormously enlarged by Dandy's reports that all that was needed was a history of recurrent sciatic attacks. Not only was the spinogram unnecessary but it was in fact useless and possibly dangerous. With the history one opened the back and wherever one found a spinous process too wiggly, one went farther and if no protruding disk was found at this level there was something just as good, namely a hidden disk. This made the whole thing simple. Dandy's early reports under this reasoning were 100 per cent perfect results, and it took several years for him to find any reasonable percentage of failures and tell about them by that time disk operators were numerous. We never seem to learn from experience. At an early meeting of the American Academy of Orthopedica, in a symposium on low back problems. I suggested that it would be a wise thing to allow the disk opera tion to remain in the hands of a few men best qualified until more was known about it, although I felt that this was very unlikely Once more the insurance companies are more impressed by failures than successes. Every one of us who have done these operations is impressed by this disproportion in our results. And yet the good results are in a discouraging percentage. We see report of good results from 80 per cent down. Dr Campbell in a careful study finds 55 per cent. This is too wide a range not to call for more study Of his 21 failures, 19 were industrial cases and 76 per cent of these were of the hidden variety. In my very limited operative experience one hidden disk was cured and one no better a matter of 50 per cent. I did a few of these cases while our neurosurgeons were in the service but have bowed out with thanks since they got back. My limited experience leads me to feel that the more damage you find the better are your results. This is so generally in surgery

Why are results so variable in an almost purely anatomic situation? I shall only express my own conclusions.

First is the difficulty of diagnosis. I am sure that disk injuries are very common and that most of them never require surgery. They get along very well at the expense of occasional bouts of back ache and sciatics for which they take maybe a short parlod in bed and some of numerous treatments, medical oscopathic, etc. They have perfect histories and findings except for neurologic findings which take a little more time to develop. Of those who go on and develop the whole picture associated with inability to carry on positive neurologic findings and a completely positive spinogram, there will be a certain number who show nothing at operation even in the hands of skilled neurosurgeons

And here I want to say that to my mind this work belongs to the skilled neurosurgeon and not to those who dabble in it. The opportunities to do irreparable damage are close to the trail, and as we have seen, the report of hidden disk, hypertrophical alar ligaments varioese veins, etc., are generally unsatisfactory to all concerned. Occasionally, the patient is cured, but that happens in every cult of healing Only ours seeks the percentages and strives to better them through more knowledge. Perhaps our greatest weakness lies in our general failure to question some of our results with the same searching enthusiasm that we have applied elsewhere. How much farther would we have been in psychosomatic medicine?

Second is the question To fuse or not? This is a problem. It offers more trauma to a patient who may have had enough. I have been on both sides of the fence and am not too sure of my stand now In general it seems unnecessary In those cases where nothing is found fusion may give good results. Let us not forget that it has undoubtedly done the trick in many cases in the past. Also in those cases where much motion between vertebrae is found and in spondylolisthesis is present despite Dandy's assurance that this is unnecessary Always remember that fusion in the lumbosacral area is not a certain procedure. The exact technic is not yet deeided. To get the best results requires exactness and care with any technic, and anatomic anomalies, so frequent in this region, may vastly increase the already difficult problem.

Third is the question Why are the results in industrial cases so generally poorer than in the nonindustrial?

One reason may lie in the almost universally deteriorating effect of insurance on the ethics of the human race as seen in the general desire to collect insurance money long after any real disability has been present. However I believe this is not one of the important reasons. Too many industrial phy sicians and those working with industrial patients are inclined to minimise complaints and to try to get these folks back to work too soon and with no change in the work they were doing. Hurt backs need rest and going to the doctor's office every day or so over varying distances for treatments is not rest. As far as my knowledge goes there are no treatments worth it. Then these patients with back injuries hear from too many people some of whom are unfortunately doctors that back injuries do not get better Each hearing they attend, in our present hearing room setup confirms them in this idea. Another important thing to know is the comparable occupational strain in industrial and nonindustrial cases. I am very doubtful as to the wisdom of sending any disk case back to the heaviest types of labor This presents a labor management problem difficult to solve especially in smaller plants.

Another possibility for physicians is the getting over to these patients that life and work with some discomfort are competible and fairly common Many of them have few resources beyond labor

### PSYCHOTHERAPY OF THE OBESE PATIENT

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THE following remarks are limited to obesity of the exogenous type, mainly as it is encountered in women. The discussion refers to individual treatment as carried out by the practitioner under the usual conditions of a medical visit. Space does not permit the discussion of other important factors, such as family relationships, or the influence of the personal, social, or economic environment.

The only way in which fat or its precursors can enter the body of the obese person is through the mouth. Fat is deposited in the tissues only when the calories of food which are absorbed through the intestinal wall exceed those which are utilized in the production of energy Obesity of all types is the result of a disturbance in the caloric bal-The patient who says-"I didn't eat nothing, doctor, and still I can't reduce"—is invoking magic, and expects a magical cure search in metabolism and endocrinology have given little indication as to how the calone balance is tipped in favor of the accumulation of fat The question, which is still to be clarified, is why the obese person eats more than she can oxidize. The fundamental questions have not been answered "What does the disease do to the patient? What does it do for the patient? How come? What to do, and how to do it?"

The only person who can supply the answers to this question is the patient. On suitable inquiry a number of motives for excessive eating can be elicited, in addition to the appetite. This is usually increased, but zest for food may be totally absent. Perhaps the most frequent complaint is a feeling of emptiness, a boundless void, which can never be filled, or which recurs immediately after eating. This feeling is intensified in situations of emotional stress. Thus it is out of proportion to the physiologic needs, and, therefore, is not so much an appetite as a craying.

In addition to the emptiness, other symptoms come to light sooner or later, resentment, guilt, self-depreciation, loss of the savor of life, and outright depression, sometimes with thoughts of suicide. Anxiety is shown by panicky sensations, inability to get a deep breath, and tightness in the throat. Gastrointestinal symptoms are common, and in older women hypertension, or attacks of anginoid pain, which is indistinguishable from coronary insufficiency.

It is clear then what the disorder does to the obese patient. It functions as a disease, in that it causes suffering, and interferes with the life adjustment. It is clear also that the illness does something for the patient, it constitutes a psychologic gain. The existence of this gain can be inferred from the manner in which the patient resists treatment, in fact it is the crux, both of the illness and of its treatment. Sometimes the gain is obvious, as when obesity is used as a way of avoiding men and marriage.

Psychiatric observation in a few cases has thrown light on this psychologic gain 1-3. The early origin of the disorder is shown in some instances by the fact that the obesity begins in the first year of life. The fundamental drive is the desire of the patient to regain the love and affectionate care which was hers without the asking when she was an infant. She has come to feel deprived of this affection and strives to compensate for the deprivation by overeating. Later this drive becomes fused with the reproductive instinct. One patient expressed this very clearly

When she eats, she says, she puts on fat around her middle, and immediately wonders, regardless of her intellect, whether she is pregnant. She has passed her menopause, and the prospect of pregnancy is remote. She has become constipated, felt "all bloated up," and wondered if she could possibly be pregnant. Even as she talks about it she feels "all puffed up in the middle." She has this feeling every time she puts on weight. Thus, she adopted a neurotic compromise by which she became pregnant in a symbolic manner by utilizing the childhood notion that impregnation takes place by way of mouth, and that pregnancy and childbirth are functions of the gastrointestinal tract.

This patient is cited to indicate that eating and the accumulation of fat in the obese woman are an integral part of a personality disturbance dating from early childhood. If this is true, the reduction of weight is only part of the treatment. The psychotherapy of the obesity, in turn, is an example of a larger problem, the treatment of the various neuroses which are encountered in medical practice. These are met nearly as often in patients with organic disease as they are in so-called functional disorders.

Symptoms such as these indicate a need for psychotherapy. The simplest form of this makes use of the emotional attitude of the patient toward her physician and his medical or dietary.

Presented at the 141st Annual Meeting of the Medical Society of the State of New York, Buffalo Section on Medicine May 9, 1947

treatment. Many doctors are skillful in this type of therapy, often without being aware of what they are doing or why It would be very useful to know how they accomplish their results

Unfortunately, psychotherapy of this type is limited in its scope. Most patients require more intensive treatment, which consists in the deliberate application of the principles of psychiatric treatment to clinical mediane. My own technic corresponds closely to the "associative anamnesis" of Felix Deutsch, 4-4 and this again to social interviewing" as carried on in social service and family case work. The similarity of these technics indicates that they are based on the same fundamental principles.

The therapist wants to know what kind of facts are useful, and how to get at them. In addition to the medical and blographic data, he needs to know the exact words in which the patient expresses them, the order in which she brings up topics for discussion, and the relation of the illness to her life history. In other words, he wants to know the spontaneous associations between the physical aspects of her illness and its mental and emotional components. Such associations are the only direct evidence for the relationship, in either direction, between mind and body

The thempist wants to know that he is getting facts, not artefacts. For this reason he avoids leading questions. He will find also that he can best make the patient talk by doing this. Moreover, he thereby leaves the patient free to form her own associations.

How does he know that the associations are significant? In the first place, all associations are significant to some degree provided that they are spontaneous Furthermore, the patient will often betray their importance by her emotional reaction She may resent the association and belittle it. She may have an exacerbation of symptoms then and there, like the patient who felt "all puffed up when she talked of pregnancy she may change the subject abruptly and talk about her previous symptoms. In so doing she is saying in effect "Oh no it's not the relation of mental stress to the illness which is important, it is the physical aspects." Thus, she is dimly aware of the significance of the association, and attempts to evade or minimize it, as in the case to be related. In all these instances the patient behaves much like the nesting bird, which pretends to be crippled in order to lead the intruder away from her eggs.

Such an interview is essentially a conversation and should have the attributes of good conversation in general. It is as far removed as possible from the question-and-answer of the routine medical history. The principle was well expressed.

by a patient, who said, "He was a good doctor, he listened " The initiative is left with the patient, but the direction is supplied from time to time by the doctor The latter remains silent until he has a reason for saying something Occasionally, he supplies a verbal stimulus or takes advantage of the patient's most recent statement to direct the conversation into productive chan nels. For instance, if the patient says something important, he can merely repeat a phrase with the inflection of a question Or he may say, "I don't quite understand,' or "Why did you say or do this?" If it is a first interview, he may utilize the pause to get medical data. If nothing is forth coming by the above methods, he can use his in genuity He may make general statements about how people feel, or cite anecdotes, or quotations, or phrases from the vernacular If the patient stops talking it is often effective to sit quietly and say nothing She may resume the conversation or perhaps respond to the query, "What are you thinking about?"

The use of the interview may be illustrated in the following case

Miss C K, came to me in December 1946 because of obesity. She was in her early twenties weighed 147 pounds and was 5 feet 61/2 inches in height. She was in good physical health, and examination showed only obesity which was most noticeable in the abdomen, hips and thighs. She has a variety of nervous symptoms to be illustrated later, together with gastrointestinal disturbances at times and on two occasions momentary periods of faintness which lasted a split second. These occurred at times when her blood sugar might have been low She came from a large city in the Middle West and of a family who were formerly in comfortable circumstances. She is the youngest of six siblings and has a married sister who is the mother of two children. She was "skinny' as a baby began to be fat at nine years and at the age of 17 she reached her maximum weight of 165 pounds She was the first to take seriously the peculiar behavior of her mother who was found to be a schizophrenic. The patient insisted on hospital care which was expensive and accomplished nothing She felt responsible for the family dissensions and financial difficulties which were the result of this To help meet the expense she left college gave up her ambition to become an artist and took a job in an accountant soffice Later she took a similar job in New York City It was at this time that her weight increased

The above summary of the biographic data was the result of five interviews. Her difficulties emerged gradually and became clearly outlined at the aixth visit. The following conversation is reproduced from long-hand notes. My part in the conversation is indicated by parentheses.

She postponed the previous appointment because

she had to move (Yes?) Things are going very badly, she broke her diet. It began Christmas day (Does she feel rueful?) Yes Everywhere she went they had to eat. She had been getting dizzy spells and felt sick. (Dizzy?) Also her

nerves were on edge

On New Year's Eve she was in one of her moods, did not give a darn. She was angry at something, no one had a good time, they had a little spat. The man and his mother had been respectful to her, but he arrived an hour late for a double date, waiting for the other girl to telephone, also he refused to leave her gift at his mother's house and they both became angry. (Was it a gift for his mother?) It was not for him. She planned a gift for him but didn't want to tell him, then she got angry and thought it didn't matter. Then she asks what bearing it has on her eating. (As a matter of fact did not she eat more?) She ate because she was bored.

She then questioned my taking notes, also the purpose of finding out what makes her eat eats when she is depressed Otherwise she can control her appetite If she is busy she doesn't think about food Don't we all get depressed? does she feel?) I get an empty feeling (What is empty?) A feeling of anxiety (A physical feeling?) It feels as though there were a clock-work in her chest, like the clock on the desk, and a lump in the (When?) She felt that way when she moved, and when she was out New Year's Eve It is a feeling of insecurity Other people moving on New Year's Eve might feel insecure (Some people might enjoy moving) She did until she said goodbye to people She had that same feeling on coming to New York from another city (Did she put on weight then?) Yes New Year's Eve should be spent with friends (She did not want to go with this man?) No She then reverts immediately to a discussion of her weight

She discusses her diet and says, "I wasn't such a bad girl" (I suppose you would like me to scold you) She is her own policeman, it is her conscience

Comment on Internew—It is significant to note that her compulsion to overeat was associated with moving and was the same feeling which she had previously on leaving her home city. Note also the fact that her escort was not the right man. This discussion led immediately to resistance, everybody has anxiety, it is natural to react that way, etc. She brings out a sensation of anxiety, a hollow place inside, and a feeling of depression, it is only during the latter that she is unable to control her appetite. Overeating is evidently the reaction, first, to loss of a dependent

It was not until two weeks later that she again discussed men She had been engaged previously and was evidently in love with her former fiance Recently he had visited her parents with her, and

position of security, and, second, to her relation

to men Apparently there is more to follow on the

latter point

had broken off the engagement, giving as a reason the difference in background between the two families. This difference was not at all obvious to me, and the patient agreed with me that it was an excuse for his indecision about marriage. Subsequently, he had attempted to revive the engagement. She was rightly concerned as to whether he could meet the responsibilities of marriage in the way in which she expected. She wanted someone to lean on, and someone to make decisions. With this proviso she was prepared to marry and to raise a family as soon as possible.

This patient shows clearly the association of obesity with anxiety, feelings of guilt, and depression. Her obesity recurred in two situations those in which she had to assume responsibility, and those in which she was frustrated. Both elements were combined in the question of marnage with the vacillating suitor.

That the question of marriage was the focal point of her emotional difficulties was evident from her long delay in discussing the problem. It would be too much of a simplification, however, to suppose that the whole difficulty was due to the suitor. It remains to be explained why she was attracted to him, rather than to the type of man whom she required as a husband. The choice of a mate is the most accurate indication of adjusted behavior or the reverse. To judge from other obese women, like the one I quoted earlier in this paper, the same psychologic drive which produced the obesity could be responsible for her choice of an inadequate suitor.

The patient took the dietary treatment into her own hands from the start. In eight visits at weekly intervals she reduced from 147 to 132 pounds, a total of 15 pounds. After her discussion of her love affair she declined further interviews, announcing that henceforth she could manage the reduction of weight by herself

No pressure was required to make her accept the diet As she said, she was her own policeman, it was her conscience. In other cases the question comes up as to how to influence the behavior of the patient, with respect to eating and to other problems. If a psychologic craving exists, no amount of exhortation or reasoning has any effect on it. The use of medical authority to enforce the diet, or predictions as to the bad effect of the obesity on health do not work much better Authority may succeed for the time being, but it is no guarantee against a relapse

To produce any fundamental change in the attitude and behavior of the patient, it is necessary to use the principles which I have described above. The technic is therapeutic as well as diagnostic, in that it permits the patient to gain insight into her own motives and behavior. The initiative for change must rest with the patient,

and all modifications of behavior should derive originally from her

Reduction of weight encounters obstacles in the form of vicious circles. One of these is physical, the greater the weight, the less the physical activity, and the less the activity, the greater the weight. This cycle is broken up mainly by the use of the diet. The dieting, however en counters another and more stubborn vicious cycle, which is psychologic It begins with a sense of deprivation at the hands of the parents This arouses resentment, which in turn evokes a sense of guilt and depression, these induce an unmanageable craving for food, which results in breaking the diet. Overeating intensifies the guilt, which induces more craving, and the cycle is repeated When a patient breaks diet, therefore the important thing is to help her see why she does it. Rather than assuming a punitive attitude, the therapist should try to ease the panes of her tyrannical conscience, or in psychiatric terms. to mitigate the harshness of her super-ego

For the foregoing reasons I do not think it expedient to use any but the mildest forms of pressure. The patient is suffering, coupled with her
visit to the doctor's office and the use of the
weighing machine, is enough. In some cases
where the personality disturbance is far more
damaging than the fat itself, it is best to omit the
discussion of the diet, at least for the time being
Such patients usually require prolonged psychia
time treatment.

An important part of the psychotherapy of obesity, as used in the case just described, was to permit the woman to unburden herself, and to see her problem in perspective This process includes the unfolding of her life history and its chronologic relationship to her obesity The visits also allowed her to verbalize her frustrations. In addition she was also able to express resentment in an atmosphere which was free of moralistic judgment. In her case the resentment was directed against her New Year's Eve escort, who committed the crime of being the wrong man Another patient might have directed her anger against someone who stood for the parent, or against the parent in person. Others might repress the resentment. In any event, the aim of the treatment is to bring the resentment to the surface, to demonstrate to the patient the person or persons against whom it is really directed, and to reduce it to its proper proportions. This process mitigates her sense of guilt and depression and permits her to acknowledge her more constructive emotions like affection for her family increased satisfaction in work, or interest in men leading to love and marriage. In married women it may lead to a happier married life When the emotional life is allowed to flow into natural channels, the compulsive quality of the eating diminishes. The ensuing reduction of weight is an index of improved adjustment. It is only under these conditions that the physician can have any confidence that the reduction of weight will be permanent.

Probably the most vital part of psychotherapy as I have described it, is to bring out and interpret the free associations of the patient which connect her emotional life with her excess drive for eating. It is only thus that she can acquire insight into her emotional life and behavior do so she requires help, because of the psychologic gain which is implicit in her illness, as in similar disorders, she resists treatment at the same time that she desires it. In other words, she resists anything which threatens her sense of se-Therefore, the therapist has to play a part through interpretation Indeed, he cannot avoid this If he says nothing the patient may construe his allence as approval or disapproval She will behave the same way with respect to his every word, movement, and facial expression

Interpretation is the chief tool of the psychotherapist and is a powerful force for good or evil The subtlety of the technic should not be allowed to obscure this fact. The success of the treatment depends on the skill with which interpretation is used Its effect for good or evil depends on the tome which is selected for interpretation, the time at which it is offered, and the terms in which it is expressed. It must not be given until the patient is prepared for it. Otherwise it may con front her with facts about herself which she can not tolerate. It is essential not to tear down a neurotic adjustment until a better one is provided. At best this angers the patient and causes her to stop treatment. At the worst it can lead to impulsive behavior which may be damaging to the patient, or in some conditions even precipitate a psychosis Unless the therapist is specially trained in dynamic psychiatry, he should make all his interpretations in an oblique, neutral, or a tentative form, and should minimize topics which are damaging to the emotional security and self esteem of the patient.

The power of interpretation, as well as the efficacy of psychotherapy as a whole, depends on the doctor-patient relationship. This is analogous to the situation which inevitably arises in psychoanalysis, where it is highly emotionalized. The patient puts the therapist in the position of a parental figure. This attitude of the patient is known as transference, and the reaction of the physician as counter-transference. The emotional impact is not so great in the medical situation, but it is much more intense than is usually realized. For instance, a woman received injections from a private physician for perindous ane-

mia, and was restored to health. One day he allowed his nurse to give the injection, which seemed to the patient to be equivalent of being abandoned by the physician. She neglected treatment for thirteen months, and came to the hospital in a severe relapse, which might have cost her her life.

The next question is also how far psychotherany should be carried in obesity, in what form, and by whom In some cases prolonged and exhaustive psychiatric treatment is necessary The decision depends on the severity of the personality disturbance in relation to the capacity of the patient to benefit by treatment For the practitioner the decision depends on his interest, the time at his disposal, his insight into human behavior, and his skill in psychotherapy He must be aware of his own emotional reaction and above all he must know when he can proceed further without risking the patient's welfare doubt, he should call for a psychiatric consultation With this backing he can decide whether to continue psychotherapy, or refer the patient to a psychiatrist He may find a psychiatric or social worker extremely helpful Often psychiatry or social service can be combined with medical treatment Thus, no arbitrary dividing line can be drawn It happens, however, that a practical line of demarcation might be drawn by means of the case herein described I confined my discussion and interpretations to her attitude toward the treatment, and to her reactions to current or recent life situations I did not use "uncovering" therapy To handle such material requires the insight and training of a psychiatrist, if harm is to be avoided

In summary, obesity of the exogenous type in women may be regarded as a personality disturbance, the physical expression of which is the accumulation of fat The obesity is almost invanably accompanied by abnormal craving for food. which is associated with a variety of nervous The fundamental treatment is psysymptoms Most patients require intensive chotherapy psychotherapy based on a deliberate application of the principles of psychiatry to medical practice. The relationship between emotional factors and eating is shown directly only by means of the spontaneous associations which are made by the patient. The initiative for the conversation remains with the patient, but the direction is supplied by the therapist Attempts to influence the behavior of the patient with respect to eating and other problems are made on the same princi-Psychotherapy inevitably includes the use of interpretations These are either made by the therapist or inferred by the patient tation is a powerful force for good or evil. Its effect, and that of psychotherapy in general, depends on the doctor-patient relationship, which is analogous to the phenomenon of transference in psychiatry The practitioner should not discuss or interpret the deeper motivations unless he has special competence as a psychiatrist. Often psychiatry or social work can be combined advantageously with medical treatment

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## ESTIMATE MEN RESPONSIBLE FOR BARREN MARRIAGES IN 30-50 PER CENT OF CASES

It is estimated that between 10 and 15 per cent of adult marriages are barren. In these the man is either a contributory or sole cause in 30 to 50 per cent of the cases, according to two San Francisco doctors writing in the July 12 issue of the Journal of the American Medical Association

Lewis Michelson, M.D., assistant clinical professor of obstetrics and gynecology at the Stanford University School of Medicine, and Robin Michelson, M.D., studied a group of 855 barren marriages of which 519 husbands had impaired fertility

In 287 of the couples the physicians collected adequate data to analyze the relative fertility of husband and wife. They state that "this study offers a challenge to physicians, in that of these 287

couples there were 99, or approximately 34 per cent, in which both husband and wife were apparently fertile, as far as could be determined (in the present state of medical knowledge), and still no pregnancy occurred "

The physicians point out "that either husband or wife may be the sole cause or both may have minor defects, the combination of which is sufficient to prevent conception. Consequently, one must not be satisfied with the finding of defects in one partner, but both husband and wife should be examined completely before an opinion is expressed as to the factors causing the infertility and the possibility of altering them "—American Medical Association News, July 11, 1947

#### A CLINICAL APPROACH TO THE OFFICE MANAGEMENT OF DIABETES MELLITUS

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TTTH modern medicine, through public health measures and recent advancement in therapy, making such astounding advancement in the morbidity and mortality in the diseases of youth and early adult life, the practitioner is becoming more and more a practitioner in geriatrics Ranking seventh among the causes of death is diabetes mellitus The frequency of diabetes is estimated at about one diabetic in every 140 people. This means that in New York State, with a population of about 14 000 000, there are about 100,000 diabetics. It behooves us, therefore, to be sure that every physician who undertakes the treatment of a diabetic is prepared competently to render this service

By "clinical approach" I mean to convey at the outset that I shall make every effort to set forth in this presentation a practical method of office management which will not be complicated by a tremendous amount of detailed laboratory procedures, which usually leads the general practitioner to despair Rather, I shall attempt to present a rational procedure based upon a sound physiology which can be carried out by any careful, conscientious practitioner To accomplish such a procedure I shall divide the problem into three phases (1) physiology, (2) diagnosis and (3) treatment.

#### Physiology

Briefly for all practical clinical purposes it is sufficient to appreciate that

- 1 Carbohydrate utilization is dependent upon
  - (a) Carbohydrate intake digestion to glu cose and its absorption
    - (b) In the presence of adequate insulin activity
      - Storage of glycogen in the liver and extrahepatic tissues
      - (2) Utilization of glucose as a source of energy

Further for practical chaical purposes, it is sufficient to appreciate that

- 2. In the presence of adequate carbohydrate utilisation there is no disturbance of associated fat metabolism.
- In the presence of adequate carbohydrate utilisation and normal fat metabolism, there is no acidosus
- Presented at the 141st Annual Meeting of the Medical Society of the State of New York, Buffalo Section on Medicine, May 9 1947

- In the presence of adequate carbohydrate utilization, normal fat metabolism, and no aci does, there is adequate hydration and a normal electrolyte balance is maintained
- In the presence of adequate carbohydrate utilization, endogenous protein is spared together with more than minimum protein intake clinically assures protein anabolism

For further practical clinical purposes, it is sufficient to appreciate that insulin activity is dependent upon

Production (islet function)

- The action of antagonists to insulin (pitus tary, adrenal, and thyroid)
- The possible destruction of insulin by toxins or ensyme activity

With this outline of the salient features of the physiology in mind, we may proceed to the second phase of the problem.

#### Diagnosis

The confusion associated with the diagnosis, in my opinion, springs from the concept of trying to group all disturbances of carbohydrate metabolism under a single disease entity which we by custom call "diabetes mellitus." If however, we adopt the concept of a disturbance of carbohydrate metabolism, then the first clinical condition with which we are confronted can be placed read ily into our concept of physiology, which we have just briefly reviewed. The question then will not be, "Is this diabetes mellitus?" Rather, it will be "This is a disturbance of carbohydrate metabolum, what disturbance is it and what steps are necessary for its control?" I am fully aware that there must be a differential diagnosis made from renal glycosuria. This is simply confirmed or eliminated by synchronous urinalyses and blood sugar determinations. Very rarely in clinical procedure does one ever see a renal glycosuma show more than 1 per cent of sugar in the urmaly All of the other disturbances of carbohy drate metabolism with hyperglycemia and glycosums with or without cardinal symptoms of what we call diabetes mellitus should be treated, in my opinion, as a "disturbance of carbohydrate meta bolism. ' For all practical clinical purposes, it is not necessary for us to wrangle over the details of the blood sugar curve. The clinician is anx ious to treat the patient and restore his physiol ogy, not to involve him in so many detailed chemical studies as to make him a nervous wreck over a

blood sugar or tolerance curve The diagnosis is made readily in the typical case with all the clinical symptoms and signs, together with a frank ketosis and acidosis Routine urinalyses pick up most of the cases at the time of a surgical complication That analysis, however, should follow a meal or some carbohydrate intake by mouth, for the fasting urine may cause a missed diagnosis Routine analyses for periodic health examinations if also taken after a meal or carbohydrate intake will find more diabetics. I offer a plea to adopt the method of taking an after-breakfast specimen rather than the time-honored convention of a "first specimen in the morning" Routine fasting blood sugars, if done, should be interpreted with a great deal of caution A mild disturbance may at the fasting period in the morning be well within the accepted concept of a normal blood To summarize, then, the clinical diagnosis depends upon the history of symptoms, the presence of glycosuma, and the elevation of the sugar content of the blood The presence of any or all of these symptoms means "a disturbance of carbohydrate metabolism," and, under these conditions, treatment is indicated

### Treatment

For all practical clinical purposes, the treatment of disturbances of carbohydrate metabolism should be directed toward certain objectives. These objectives are

- 1 Elimination of ketosis and acidosis
- 2 The maintenance of fluid and electrolyte balance
- 3 Adequate nourshment of the patient, including adequate carbohydrate utilization, protein supply, total calories, vitamins, and minerals in the diet
- 4 Control of carbohydrate physiology (excrete less than 10 Gm in twenty-four hours)
- 5 Assurance of protein anabolism by (a) adequate carbohydrate utilization, and (b) more than the minimum requirement of protein intake
- 6 Psychologic approach to assure a mentally well-adjusted patient

These objectives are attained by only one method and that is diet or diet together with insulin. There is no mouth medication of value in this disease.

Let us first consider the diet There are two factors to which one must adhere rigidly First, the diet must be fixed By this I mean that the patient must eat the same amounts of carbohydrate, protein, and fat each day The actual form of the food should be varied by substitution but the amounts of carbohydrate, protein, and fat contained therein must be the same each day

if control is to be attained. The second essential factor is that the diet must be adequate. By adequate I mean that it must (1) satisfy the patient in form and volume, (2) it must provide normal energy to permit usual activity, (2) it must provide calories to maintain a normal weight, to reduce if obese, and to gain if underweight, (4) it must provide adequate vitamins and minerals, and it must provide adequate protein. These criteria for adequateness of diet are simply and practically attained clinically by providing a typical American diet.

TABLE 1 -BASIC DIABETIC DIET

Breakfast		*C	P	F
1/2 cup orange juice	100 Gm.	10	1	0
1/2 cup cooked cereal	100 Gm.	11	3 6	0 1 8
1 oup milk	$200~\mathrm{Gm}$	10	6	8
1 slice bread	30 Gm.	15	2	0
2 eggs		0	12	12
1 pat butter	10 Gm	0	0	9
Coffee		0	0	0
Breakfast totals		46	24	30
Lunch				
1/2 cup 10% fruit	100 Gm	10	1	0
1 cup 5% vegetable	200 Gm	10	1	0
1/2 cup 10% vegetable	100 Gm.	10	1	0
1/4 lb ment	120 Gm.	0	29	11
1 cup milk	$200~\mathrm{Gm}$	10	6	8
1 ounce cottage cheese	30 Gm	1	6	0
1 slice bread	30 Gm.	15	2	0
1 pat butter	$10~\mathrm{Gm}$	0	0	9
Lunch totals		56	46	28
Supper				
1/2 cup 10% fruit	100 Gm.	10	1	0
1 cup 5% vegetable	200 Gm.	îŏ	ī	Ō
1/2 cup 20% vegetable	100 Gm.	20	ž	0
2 ounces American cheese	45 Gm.	ō	12	15 8 0
1 cup milk	200 Gm	1Ŏ	6	8
2 slices bread	60 Gm	30	6 4	0
C			_	23
Supper totals		80	26	
TOTALS FOR THE DAY		182	96	81

\* C = carbohydrates, P = proteins, F = fat.

Around this regular diabetic diet, which I call "basic," most diets can be built If the volume of the diet is too large, more concentrated vegetables can be substituted If this diet is too small in volume, more 5 per cent vegetables can be substituted for the 10 and 20 per cent vegetables The amounts of carbohydrate, protein, and fat total 180, 100, and 80 Gm, respectively, and a total of 1,840 calories If this caloric intake is too low, the calories can be raised readily by increasing the butter Around such a typical American diet, additional variations can be made to suit the individual patient. In this fashion a diet is provided accurately and, with the cooperation of the patient, the diet can be fixed easily and adequately Some knowledge of food values is necessary, but reference tables are used at first

For all practical clinical purposes the patient is put on such a fixed diet as a trial diet. After a few days to a week, a twenty-four hour urine specimen is collected and the volume measured by the patient. A quantitative sugar determina-

tion is then made upon this specimen in the doc-The volume of the urine in cubic centimeters multiplied by the percentage of sugar gives one the total grams of glucose excreted in the twenty-four hour period. From the diet we know the total sugar intake or the available sugar intake. We have calculated the total sugar output and the subtraction of these two gives us the total utilized by the patient. Repeated follow-up determinations of sugar utilized, weight activity, and symptomatology soon lead us to a children concept of the severity of the carbohydrate disturbance, and insulin indications the patient is able to render his twenty four hour specimen sugar free on such a diet, and maintain his weight and usual activity, he shows no indication for the use of insulin. If the patient excretes more than 10 Gm of sugar and loses weight and you are sure he follows the diet, he requires insulin (If the patient should excrete a great percentage of the available sugar in the diet, and thus the apparent figure of utilization is little or none, but he gains weight obviously. this patient is breaking the diet.)

Briefly, if the objectives of treatment as outlined above are attained by diet alone, insulin ad ministration is not indicated. If the objectives of treatment are not so obtained, then diet together with insulin is indicated. The indications for or against mulin administration are clinically practically dependent upon a careful observation of

the carbohydrate utilization

#### Use of Insulin

The most important factor in insulin administration is the desage. This is determined by estimation of the amount of sugar not utilized or that which is excreted in the twenty four hour specimen Insulin is the only medication used to increase the amount of carbohydrate utilized Using the amount of sugar excreted in grams in twenty four hours as a guide makes for a simple clinical approach to the determination of the dosage. In a broad general way one unit of protracted-acting insulin will provide for the utilization of about 4 or 5 Gm, of excreted sugar in the twenty four hour specimen. For the practical approach it is best to start at about one unit for every 6 Gm. and at subsequent observations increase the dose gradually This precuation will avoid insulin hypoglycemia which is so disturbing to the psychic adjustment of the patient. The vast majority of patients will be found to be brought, by diet together with a single dose of protracted-acting insulin before breakfast, to a state of carbohydrate utilization which attains our objectives of treatment. One must always remember that with globin insulin the time of most frequent hypoglycemia is late afternoon and with protamine sine insulin, the night and early morning. This is to be anticipated if the twentyfour hour urine becomes sugar free or very nearly so. Afternoon or bedtime snacks of fixed amounts are a simple method of avoiding shocks.

In a small percentage of cases adequate carbohydrate utilization may be attained only by the administration of both protamine and shortacting insulin. For the most part, these are cases in which the estimated does determined by the sugar-excreted method exceeds about fifty or sixty units. In these cases the simplest method in my experience has been to use a fixed mixture of two parts regular and one part protamine sinc insulin. The desage of this mixture is deter mined in the same fashion as described above. With these few simple suggestions as a guide for the use of insulin and diet, almost all of the uncomplicated adult diabetics can be assured an adequate utilisation of carbohydrate and in this way attain the objectives of treatment.

#### Summary

A practical clinical method of office management of the adult uncomplicated dilabetic patient is suggested. This method is based upon the principle of observation and determination of the total carbohydrate utilized from a fixed diet adequate in all respects. A simple method of insulin design is also offered based upon the amount of carbohydrate excreted. Protracted-acting insulin or two to one (regular to protamine sine) fixed mixtures are recommended as most convenient and adequate. These broad general principles have proved very satisfactory in attaining our objectives of treatment in my experience with adult diabetic patients.

#### Discussion

Dr Harold F Brown, Buffalo -- Dr Williams paper is important in that it stresses the need for accurate follow-up on patients who have been discharged from the hospital or who could not have the advantages of hospital education. I believe that every patient with diabetes should be considered as a broad medical problem and not as simply one of a chemical abnormality. In training patients to look out for their own diabetes dictary services are necessary as doctors are not trained as dictitians. It would be useful to have the services of dietitians available to all doctors because after all, the patient s diet is still an important part in treatment tor cannot expect success if he tells his patient just to omit sweets from his diet or even to hand out a diet sheet which is to be followed every day by the patient without substitutions.

The diagnosis of diabetes may be extremely difficult, but it is usually simple. The Exton Rose glucose tolerance test appears to be quite satisfactory and requires much less time and effort on the part of the physician and the patient. It is important when a diagnosis is to be made that the patient be on at least 300 Gm. of carohydrate several days before the test It is also necessary that the patient be free from infection and hyperthyroidism at the time the test is carried out

Patients must be given diets which they can stay on and still carry on their work. In using protamine zinc insulin, which is the basic insulin for all treatment, I find it necessary to give four meals a day in order to keep the patients free from reactions and heavy glycosuria. In doing this one must give relatively large amounts of protein, from 80 to 100 Gm a day

It is my belief that there is more to be gained by the carrying out of fractionated qualitative urine sugar tests rather than the quantitative examination of twenty-four hour specimens, as it is well known that diabetics have sugar in their urine at one time of day, whereas they are free of sugar at another That gives one a better idea of how to alter the dosage of insulin

One of the great problems that besets us is the care of the obese diabetic. They have established their eating habits, and it is difficult to alter those. Food is to them like alcohol is to an alcoholic, and it frequently becomes a psychiatric problem. If these patients are given insulin, they increase weight When they increase weight, it is necessary to give more insulin, so that if you are not successful in maintaining a reduced diet all treatment fails.

The determination as to how accurate the control should be must be an individual problem in every case. One strives to keep diabetes under continuous control, but this cannot be done always. We simply do the best that we can with what is at our command under all circumstances.

# SCIENTIFIC EXHIBITS 1948 ANNUAL MEETING

Applications for space for the scientific exhibits should be made directly to Chairman of Subcommittee on Scientific Exhibits of the Convention Committee

Dr J G Fred Hiss 505 State Tower Building Syracuse 2, New York

The Annual Meeting will be held May 17 to 21, 1948, at the Hotel Pennsylvania in New York City

No Applications can be considered after January 15, 1948

There will be two groups of awards

Awards in Group I are made for exhibits of individual investigation, which are judged on the basis of originality and excellence of presentation

Awards in Group II are made for exhibits which do not exemplify purely experimental studies and which are judged on the basis of excellence of presentation and correlation of facts

W P ANDERTON, M.D., Secretary

#### HEALTH SUPERVISION OF THE INFANT AND PRESCHOOL CHILD

EDWARD R SCHLESINGER, M.D., MPH, Albany, New York

(From the Division of Maternal and Child Health, New York State Department of Health)

R COENT major advances in the medical sciences have insured a continuation of the spectacular decline in mortality and scrous illness during infancy and the preschool period which has occurred over the past three decades in the United States. These developments, furthermore, bring a broader objective into view the provision of adequate health supervision for every infant and preschool child.

In a broad sense, health supervision of the in fant and preschool child guides his physical, mental, and social development toward the goal opperimal physical health and a well-adjusted adult personality It consists of four basic elements.

#### Basic Elements in Health Supervision

- 1 Periodic Medical Examinations to disclose the presence of physical defects and deviations from normal physical growth and development. Discovery of the defects and other abnormalities is followed regularly by steps leading to more want diagnosis and to the correction of physical defects and other abnormalities which are amenable to treatment. This implies a knowledge of community resources and a determination to utilize these resources.
- g Immunizations to protect the infant and preschool child against communicable diseases of special hazard to the young child The infant may be protected effectively against diphtheria, amallpox, whooping cough, and tetanus. Protection against these diseases is stimulated by additional small injections before the child's entrance into school.
- 5 Supermoon of the child's nutrition with particular emphasis on providing the necessary supplements of vitamins A, C, and D Breast-feeding is oncouraged unless specifically contraindleated.
- 4. Attention to the psychologic and social aspects of growth and development to prevent the development of behavior difficulties. Parents are prepared in advance for the successive stages of normal development. For example, they should anticipate the decrease in food intake that normally occurs about the time of the infant's first birthday. They should be made aware of the sharply negativistic phase through which a child

normally advances at the age of two and one half years. Understanding guidance rather than coercion during this stage of personality development may prevent later behavior difficulties

#### Responsibility for Health Supervision

Should the responsibility for health supervision of the preschool child fall on the pediatrician or the general practitioner? Although the pediatrician may be best qualified by training for such supervision, the size of the problem makes it clear that the general practitioner must provide the greater part of the care A generally accepted schedule of supervision consists of monthly visits up to nine months of age, trimonthly visits between nine months and two years of age, and semiannual visits thereafter until six years of age. For the estimated 600,000 children under six years of age as of July 1, 1946, in upstate New York (New York State exclusive of New York City), meeting such a schedule would entail more than three million visits annually, or 92 visits per pediatrician each working day for each of the 130 practicing board-qualified pediatricians in upstate New York on that date

The distribution of pediatricians makes it even more difficult for them to cover more than a small part of the necessary preschool health supervision services. Of the 130 pediatricians, 99 reside in seven of the 57 upstate counties. There are no pediatricians located in 32 counties, or 56 per cent of the total. With the added factor of travel involved, it is apparent that pediatric specialist services are spread very thin over large areas of the state.

Responsibility for child health supervision for the greater part of the preachool population, therefore, must fall upon the general practitioner Through the welter of propaganda about infant and child care on the radio and in the press, the average parent still looks for guidance to her own physician. If the private practitioner could discharge this function completely without help there would be no need for an organized program of health supervision under public health auspices. Many factors, several beyond the control of the physician, make it extremely difficult or even impossible for physicians in private practice to devote the needed attention to this phase of preventive medicine.

In areas of greatest need, such as rural areas with high birth rates, physicians are preoccupied with care of the sick patient. Some physicians have only casual interest in the presumably healthy child, largely because so little attention was paid to this subject during his undergraduate medical course and because provision of certain health supervision services requires the assistance of other than medical personnel, as will be shown later.

From the parent's viewpoint, the mother may hesitate to bring her infant or preschool child to an already overburdened physician for routine This may be due to her desire to supervision spare the physician or because of the inconvenience involved in waiting her turn with a fretful child on her hands Many parents of preschool children most in need of this service make no effort to obtain such care, due to their ignorance of the value of health supervision Furthermore, it is generally acknowledged that health supervision by physicians in private practice is one of the earliest services to be eliminated under economic stress For these reasons, and to meet the public need, it is necessary to apply mass technics at least as a supplement to private practice

## Purpose of the Child Health Conference

One such technic is the child health conference. in which groups of children under six years of age may be given health supervision at great economy of time and effort The conference does not displace the private physician even from the field of preventive medical care Experience has shown that the child health conference has enhanced the opportunities of the local physician in that he has referred to him many children for diagnosis and treatment whose difficulties might not otherwise have been brought to medical attention child health conference is not a treatment clinic and it is not set up to take care of sick children Furthermore, acutely ill children are excluded from the conference entirely to prevent spread of infection

This service for preschool children has been accepted since the early 1920's in wide areas of the State—Initially, an itinerant team of physicians and nurses conducted conferences at irregular intervals in scattered localities at the request of the local health officers—In 1925 a dental hygienist was added to the team—As the idea took hold, communities established their own conferences so that the itinerant program was dropped in 1935. The peak was reached in 1940 when 4,400 conferences were held in 240 separate communities. During the course of 1940 approximately 50,000 children were seen—Since that time there has been a marked decrease in the number of confer-

ences held, so that in 1945 only 2,500 conferences were held in 220 communities. This decline was undoubtedly due, in large part, to wartime conditions and the concomitant acute shortage of medical and nursing personnel. A resurgence of interest in child health supervision has occurred in the past year with the return of physicians from the services and the general relief from war-connected activities.

Child health conferences have been supported financially in varying ways. The entire cost may be borne by the local governmental unit or, under the State aid-to-municipality program, the municipality may be reimbursed to the amount of at least 50 per cent of the cost by the State Department of Health Finally, the conference physician's fee may be paid directly by the Department for a limited period of time as a demonstration

During the developmental years of the conferences the policies and services of such conferences have varied from place to place. Participating in the conferences, although almost never at the same time, have been physicians, public health nurses, nutritionists, dental hygienists, lay volunteers, and, very rarely, social workers. Some areas have admitted all children, including those receiving adequate private medical supervision, whereas others have excluded such children. Still other localities have employed a means test.

# Duties of Personnel in the Child Health Conference

To set a goal, it might be well to enumerate the personnel and outline their duties in a well-run conference No conference should be held without a physician and a public health nurse physician takes a short history, examines the child, dictates the results of the examination to a clerk or volunteer worker, and discusses any posttive findings with the parent in order to impress upon her the importance of further care for complete diagnosis and possible treatment physician further advises regarding the feeding of infants and preschool children, including formulas for infants who are not breast-fed, and he emphasizes the importance of supplements of vitamins A, C, and D The public health nurse manages the conference, further interprets the physician's recommendations, and performs the necessary follow-up in the home

Additional personnel may include the nutritionist to give detailed nutrition instruction. In practice, it is preferable for the nutritionist to act as consultant to the public health nurse and to have the nurse include nutrition instruction as an integral part of her educational work at the conference. The dental hygienist does a dental prophylaxis and educates the mother in the necessity

for care of the child's teeth by a dentist A medical social worker is available for consultation with other personnel of the conference, but it is not expected that medical social workers will often be available to attend the conferences themselves. The lay volunteer workers assist in various nonprofessional tasks, such as transportation of parents and children in rural areas and assistance in weighing and measuring the children.

It is essential that all children not under regular medical supervision should be eligible. Previously there has been duplication of effort as children adequately supervised by physicians were brought to the conference by overanxious parents. For the rural and small urban areas no other limitations on eligibility should be imposed.

For various reasons, in many preschool children not under regular health supervision, minor conditions are neglected and early major deviations from the normal are not discovered. The child health conference makes it possible for children with these conditions to be referred to the private physician for care.

# Services Available in the Child Health Conference

The better conference offers certain services not available to the general practitioner, such as dental prophylaxis, as well as other services which the private physician often does not have suffi cient time to develop, for example, detailed in structions in food preparation and education in regard to development of normal behavior patterns. Physicians, therefore, are encouraged to utilize the conference for any specific services they may indicate The only limitation in this regard is that children may be referred for dental prophylaxis only in those areas in which this service cannot be readily obtained from private sources. It should be emphasized that children are referred only for specific preventive services and not for diagnosis or treatment.

To improve the medical services at the child health conferences, charts are being used to record serial observations of weight and height of infants and preschool children Such a graphic presentation may assist the physician to evaluate the child's development. Recently, the Jackson Kelly growth charts have been introduced on an experimental bases in a few child health con ferences 1 These charts appear to be the most effective of those available covering the entire preschool period They are simple to maintain and the simificance of the findings is easily apparent The charts cover three age periods with different forms for each sex. The ones used in child health conferences cover the first year of life and the entire period from birth to six years. If they prove to be valuable, they may be transferred to the school record to serve as a baseline for serial observations during the grade-school years

Inasmuch as one of the primary functions of the child health conferences is that of screening abnormalities, it is proposed that simple laboratory tests be performed. The Phillips hemoglobin test which utilizes standard copper sulfate solutions is an ideal acreening test.2 Only one concentration of copper sulfate solution need be used and a standard solution for readings above or below 11 Gm. of hemoglobin is available from the State Department of Health for use in local child health conferences. All children whose hemoglobin levels are below a reading of 11 Gm are referred to the private physician for further diagnosis and treatment. In no sense is this test diagnostic, since it merely discloses the presence or absence of anemia and not the condition which has produced anemia.

Immunisations are an important part of child health supervision. If the entire State were served adequately by child health conferences, there would be no need for separate immunisation clinics for preschool children Full utilisation should be made of child health conferences to in crease the number of preschool children immunised against diphtheria, whooping cough, small pox, and totanus. Immunisations against these diseases can be completed by the time the infant is seven months old according to the following schedule.

- Immunization against whooping cough at three, four and five months of age
- Vaccination against smallpox at aix months of age
- 3 Immunisation against diphtheria and tetanus with precipitated toxoids at six and seven months of are
- 4 Smaller stimulation doses should be given to preschool children against diphtheria, tetanus, whooping cough, and smallpox at between three and six years of age.

Printed material to assist in the educational aspects of the child health conference is to be made available rapidly. A series of leaflets

<sup>\*</sup> Although the American Academy of Pediatrics recommends immunisations against diphtheria, whooping cough, and tetanus at a slightly older age it must be recalled that the recommendations of the Academy are primarily intended for children are generally in better circumstances and less exposed to the danger of infection. Furthermore recent evidence has indicated that early immunisation against whooping cough is effective. Even though protection against whooping cough may not be so complete when because three months as opposed to air months, and this is still a moot point, a significant level of protection is conferred at the period of life when the disease is most dangerous.

entitled, Food for Baby, has been distributed as an aid in interpreting the recommendations made by the conference physician in regard to infant feeding. Work is proceeding on another series of leaflets on normal growth and development and the minor behavior difficulties of the preschool period. A manual of reference material for use at the child health conferences is being prepared.

### Summary and Conclusions

Health supervision is an essential part of the preschool program whether given under private or public auspices Many communities can provide

this service efficiently through the child health conference. Through the various measures discussed, it is hoped that the child health program may be expanded throughout upstate New York to meet this very evident need.

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### NEW SYNTHETIC PLASTIC PROVES ITS VALUE IN BRAIN SURGERY

Experiments on animals indicate that polyethylene, a new synthetic plastic, may fill a long-felt need in surgery

In the September 13 issue of the Journal of the American Medical Association, three members of the neurosurgical service of the Children's Hospital and the Department of Surgery of the Harvard Medical School report a number of experiments in which pure polyethylene in the form of tubing or film was implanted safely into the tissues of cats, dogs, monkeys, and rabbits. This is important because, according to the writers, "up to the present time, no plastic material which can be formed into pliable tubing as a substitute for rubber or into thin film to replace normal membranes in the body has been found"

The authors of the article, Franc D Ingraham, M D, Eben Alexander, Jr, M D, and Donald D Matson, M D, all of Boston, describe polyethylene as a tough thermoplastic resin which does not need the addition of another chemical compound to make it flexible and phable—It is almost transparent, will stretch without breaking easily, is lighter than water, is resistant to most of the common solvents, and its physical properties are not significantly changed by ordinary climatic temperatures or by the range of

body temperature changes Used extensively in the manufacture of airplanes as an electric wire insulator, it has been produced in the United States since 1943

As neurosurgeons the writers were chiefly interested in the reactions produced by this plastic in the central nervous system and its coverings. Two types of experiments were undertaken with animals (1) inserting pure polyethylene directly into the tissue of the cortex of the brain, and (2) cutting out a portion of the dura—the outermost, toughest, and most fibrous of the three membranes that envelop the brain and spinal cord—and replacing it with pure polyethylene film

Tissue reactions were studied in 43 cats, 10 dogs, 9 monkeys, and 3 rabbits "None of the animals showed evidence during life of cerebral irritation or of any unusual behavior that could be attributed to the presence of polyethylene," state the doctors. Examination after death showed that there had actually been no foreign body reaction Further experiments, undertaken because previous studies have shown that certain forms of plastic and rubber tubing cause penicillin to become less effective, indicated that this is not the case when pure polyethylene is used.

### GENERAL DISTRIBUTION OF ANTIMENINGOCOCCUS SERUM DISCONTINUED

The general distribution of antimeningococcus serum, produced by the State Department of Health Division of Laboratories and Research since 1916, has been discontinued. It will be supplied hereafter only by the Central Laboratory, Albany, the Branch Laboratory, New York City, and the supply station in the Department of Health, Buffalo The need for antimeningococcus serum has greatly diminished following the use of sulfonamide drugs and antibiotics

However, even during the current period of low incidence of meningococcal infections, considerable quantities are still being distributed (718 vials in 1946)

Continued demands may necessitate resumption of serum production, suspended in 1945. The change in distribution procedure has been made to conserve the present supply—Health News, October 13, 1947.

### HEAD TRAUMA AND HYPERSENSITIVITY OF THE CAROTID SINUS

ARTHUR D ECKER, M D, and IRVING L. ERSHLER, M D Syracuse New York

(From the Departments of Surgery (Neurosurgery) and Medicine Syracuse University College of Medicine)

FOR many years it has been known that presgrame over the carotid artery may cause slowing of the heart and a drop in arterial blood pressure. Hering was the first of the more recent investigators to show that the carotid sinus is richly supplied with sensory nerve fibers. These afferent fibers emerge from the arterial wall traverse the intercarotid area, and proceed to the brain stem.

In the past twenty years much has been written about the physiologic and clinical implica tions of the normal and of the hypersensitive carotid sinus 4-4 Little attention has been paid to the causes of hypersensitivity of the sinus. Etiologic considerations were summarized by Weiss as follows "In instances in which the carotid sinus nerve or nerve endings are hyper sensitive because of local disturbances (arteriosclerosis, inflammation pressure by tumors and neoplasms), abnormal afferent impulses may arise following normal stimulation. In other instances normal afferent impulses from the sinus may set up abnormal reactions as the result either of changes in the threshold of central synapses (neurosis), or of increased sensitivity of the motor nerve ending or effector organs resulting from disease (coronary sclerosis and thrombosis) combination of these three factors may play a role in individual cases." 1

Throughout the years there have been occasional suggestions that trauma to the neck may cause intense stimulation of the carotid sinus. A review of the literature failed to disclose evidence of close association between trauma of the head and neck and subsequent hypersensitivity of the carotid sinus. However, in the course of preparation of this paper, there appeared the report of one such case In 1945 one of us (A. D L.) reported 4 cases of spasm of the internal carotid artery following such injury 7 In one of these cases, an instance of blunt injury to the head, there were ischemic changes in the wall of the internal carotid artery within the carotid canal. It is possible that in cases of a direct blow to the neck or sudden extension or lateral flexion of the head there may result stretching and spasm of the internal carotid artery in the region of the carotid sinus Such spasm, in turn, may produce hy poxia of the arterial wall and resultant hypersensitivity of the sinus Four cases are herewith

Presented at the 141st Annual Meeting of the Medical Hociety of the State of New York, Buffalo May 8 1037 Section on Neurology and Psychiatry presented in which such a course of events may

#### Case Reports

Case 1 -The patient was a 22-year-old man a college athlete who had previously been well During the first round of a boxing match on Feb 9 1946 the patient received a "head butt ' to the skull just above and behind the left eye He did not lose consciousness and was able to finish the scheduled three-round match, Subsequently he developed syncope and his pulse rate was found to vary between 42 and 48 per minute. Accordingly he was hospitalized at the Student Infirmary Physical examination was entirely negative except for the findings noted above and a left subconjunctival hemorrhage For the first few days he could not assume an erect position because of faintness and giddiness. After a few days he was able gradually to resume moderate activity but his pulse remained Pressure on the left caroud sinus produced asystole for fifteen seconds X ray study of the skull was entirely negative. The spinal fluid was negative in all respects. On Feb. 17 1046 the patient a pulse rate was 44. Twenty five minutes following the administration of 1/100 grain of atropine sulfate the pulse rate was 60. In brief this was a case of hypersensitivity of the left carotid simus following head injury with forced flexion of the head to the right Subsequent studies over a period of several months revealed that the patient s pulse rate was normal and that he was free from symptoms.

Case 2—The patient was a 31 year-old white man. About ten years ago he received a blunt head injury during a football game and was rendered unconscious for several minutes. The clinical findings immediately following the injury are lacking. For the past year he has had recurring opisodes of headaches faintness and giddiness Examination now reveals hypersensi vity of each carotid sinus of the 'corebral type.

Case 3 -The patient was a 17 year-old white man. On Dec 19 1940 while climbing down a ladder the patient fell eleven feet to the ground During the fall he struck the right side of his forehead on the ladder. He was not dazed and did not lose consciousness. Headache persisted and vomiting occurred two days later When seen four months later the patient had complaints of headache and episodes of unsteadiness. Examina tion revealed no abnormality of the nervous system Pressure on the right carotid sinus caused slowing of the heart rate headache and unsteadiness of the same type the patient had experienced when he assumed the erect position. Pressure on the left carotid sinus caused neither change in heart rate nor subjective disturbances This was, therefore a case of hypersensitivity of the right caretid sinus

following a blunt trauma to the right frontal region Case 4 -- The patient was a 41-year-old white man with the chief complaint of frequent episodes of vertigo On Feb 20, 1939, he was struck on the right frontoparietal region by a falling metal drum which weighed 27 pounds He immediately lost consciousness for several seconds remaining at home for three days, he returned to work but complained of episodes of lightheadedness Thereafter, he noticed that when he moved his head suddenly up or down he would have a sensation of whirling and occasionally some nausea tion ten months after the injury revealed that pressure over the left carotid sinus with the patient in the erect position resulted in prompt loss of consciousness, a few clonic movements in all four extremities, and a precipitous drop in blood pressure Repetition of carotid sinus pressure after recovery produced the same clinical picture and also slight On assuming the supine position recovery was prompt and complete Pressure over the right carotid sinus for forty-five seconds was marked only by transient faintness and a very slight rise in pulse rate (from 90 to 100) The blood pressure remained constant at 128/65 In brief, this was a case of hypersensitivity of the left carotid sinus which began immediately following a blunt head injury

### Discussion

Data on 4 cases have been presented, in each of which hypersensitivity of the carotid sinus followed blunt injury to the head The patients were all white men and were 22, 31, 17, and 41 years of age, respectively There was no evidence of arteriosclerosis or of psychoneurosis in any case. In 3 of the cases the symptoms began immediately after the trauma, whereas in 1 case the symptoms did not begin until nine years after the trauma

One of the most common causes of arter spasm is traction on the vessel One of us demonstrated ischemic changes in the wall of internal carotid artery following violent late flerion of the head to the opposite side 7 Me described a case of severe head trauma will much traction on the carotid artery that tea of the intima and thrombosis resulted 8

These cases are presented to call attention the possibility that head trauma may be a ca factor in the production of hypersensitivity the carotid sinus It is hoped that there will further investigation of this subject

### Summary

Four cases are presented in which hypers tivity of the carotid sinus followed a blunt in to the head In 3 of the cases the carotid sy toms appeared immediately after the train In the production of the head injury there have been enough extension or lateral inclina of the neck to exert traction on the carotic tery Such traction may have caused tempo spasm and hypovia of the arterial wall in region of the carotid sinus and resultant pe nent hypersensitivity of the sinus

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# ROCKEFELLER FOUNDATION GRANTS \$31,500 TO CONTINUE TWIN STUDY

The Rockefeller Foundation has made a second appropriation to enable the department of medical genetics of the New York State Psychiatric Institute, New York City, to continue its twin study on the problems of aging for another three-year period beginning February 1, 1948 This second grant is \$7,500 more than the first appropriation of \$24,000 made nearly three years ago

In announcing these developments, Dr Nolan D C Lewis, director of the Psychiatric Institute, reported that very satisfactory progress is being made in this state-wide twin research project on the con-stitutional problems of aging and longevity as organized by Dr F J Kallmann and his staff of assistants

Due to the cooperation of the general public,

the medical profession, and many hos administrations and welfare agencies, the number of twins over 60 years of age available study approximates 1,500 ranging up to 94 years. Of this number about 950 twins are still the majority of them living in their communit part of the general population without requ institutionalization or old age assistance

The potential merits of these long-range st on human personality are reflected in the magn of the grant from the executive committee o Rockefeller Foundation This grant will ma possible to continue the observation of this un sample of senescent twins until most of them, completed their life span -Mental Hygiene September, 1947

# ; ARKINSONISM—IS IT A SURGICAL PROBLEM?

EFFERSON BROWDER, M D, Brooklyn, New York

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E The EDICINAL and physical thempeutic measures for the alleviation of tremor and langidity of Parkinson's disease have resulted in ≠moderate, but usually transitory, improvement in Tsome patients In others, little benefit has been derived from these therapies. Failure to effect a cessation of the tremore, in particular, by these so-called conservative means has stimulated sur geons to explore the possibility of favorably modi lying this distressing symptom by operation That this is not strictly a modern endeavor is attested to by the reports of Horsley, 1890, 1909,1 Anschuetz, 1910,2 Payr, 1921,2 Nazaroff, 1927 Polenow, 1929, etc., concerning the surgical treatment of a somewhat comparable dyskinesia, namely choreoathetosis It may be said, however, that for the most part our present-day con cepts regarding the surgical treatment of parkinsonism have been derived from the observations of Bucy, 6-8 Putnam, 9-11 and Meyers 12-14 In 1940 Klemme very briefly reported his surgical experiences with 100 cases of parkinsonism.18 Up to the present time, Klemme's writings have not clarified thoroughly the extent of his surgical procedure, nor do they present a concrete picture as to the end results

From the reports available in the literature and my own observations it seems reasonably well established that the tremor as well as the rigidity of the disease under consideration may be modi fied by (a) excision of a part of the premotor cor tex, (b) undercutting of the premotor area, (c) division of the anterior limb of the internal capsule, (d) section of the pallidofugal fibers, or (e) interruption of the lateral pyramidal tract at the second cervical segmental level. Whether or not any of these surgical procedures result in sufficient symptomatic improvement to justify their employment has been questioned by many truth, even neurologic surgeons frequently have raised just this issue and, it seems to me, rightly Therefore, it becomes necessary that those actively interested in surgical therapy for parkinsonism must report their results with a more objective attitude lest this therapy fall into disrepute.

Certainly one should not consider, except in the most unusual circumstances paralyzing a limb in order to deprive it of a tremor. Nor should one

subject a patient to a major surgical procedure without reasonable possibility of rehabilitation. Furthermore, the operation proposed should be one that can be executed successfully by anyone familiar with cerebral surgery

I have had the opportunity to observe 33 pa tients with parkinsonism upon whom either a spinal or cerebral operation had been performed Four of these had had a part of the premotor cor tex removed by Klemme, 4 had a section of the lateral pyramidal tract carried out by Putnam, 12 had been operated upon by Meyers while he was associated with me, using a variety of procedures that is, undercutting of the premotor cortex and removal of a part of the caudate head in 2 cases extirpation of the head of the caudate nucleus and section of the oral half of the anterior limb of the internal capsule, 4 cases, extirpation of the head of the caudate nucleus and oral thirds of the puta men and globus pallidus and interruption of the fibers running in the oral fourth of the anterior limb of the internal capsule, I case and section of the pallidofugal fibers 5 cases

The remaining 13 patients were operated upon by me. In each of these 13, the dorsal half of the head of the caudate nucleus was first removed and the fibers of the anterior limb of the internal capsule sectioned up to a few millimeters of the genu. Only unilateral operations were performed in this group

Although this series of 33 cases is admittedly relatively small and it seems probable that the 4 of Klemme s and 4 of Putnam s therein included may not represent a fair sample of all that they have treated surgically, yet the results as I have observed them will be reviewed briefly but pointedly Of the 4 operated upon by Klemme 3 had bilateral tremor and ngidity prior to opera Following a unilateral operation in each there resulted a marked spastic hemiparesis with out rhythmical tremor in 2 cases and, in the third a spastic hemiparesis with occasional outbursts of irregular tremor on the paretic side. The remaining patient had what may be termed uni lateral parkinsonism He was rehabilitated completely at the time I saw him, eighteen months after operation

One of the patients operated upon by Putnam presented a most interesting result. Seemingly there had been marked rightly with minimal tremor bilaterally before operation. Two years after operation there was marked reduction in

Presented at the 141 t Annual Meeting of the Medical Society of the State of New York, Buffalo Section on Neurology and Psychiatry May 8, 1947

rigidity of the extremities on the side homolateral to the operation with an occasional transitory tremor in the upper extremity which had an amplitude far greater than the relatively fine tremor of the unoperated side Although this patient had not been rehabilitated by the cordotomy, the rigidity of the extremities on the side of the cervical operation had certainly been reduced markedly The results in the other 3 patients of Putnam were not good, in fact, they should be considered total failures In the series of 12 patients reported by Meyers, operated upon on my service, a variety

of operative measures were tried The first operation was performed in March, 1939, at which time the premotor cortex of a young woman was undercut without apparent alteration in the rigidity and tremor limited to the extremities of the left side Following this. at the same operation, a part of the head of the caudate nucleus was removed There was complete cessation of the tremor and favorable modification of the rigidity for three and a half years The tremor returned in the latter part of 1942 and persisted unchanged until last seen in 1946 the remaining 11 patients, 6 were somewhat improved by the procedure or combination of procedures employed A review of all the clinical and operative features of these 6 leaves me with the conviction that it was damage to the fibers of the anterior limb of the internal capsule that produced the modification of the tremor rather than the direct attack on the basal gangha the remaining 5 patients had an enduring marked hemiparesis and recurring convulsions One subjected to section of the pallidofugal fibers was improved markedly as regards tremor and rigidity but as a by-effect of the operation there was diabetes insipidus and impaired control of the vesicular sphincters Three of the 12 died from complications arising from the operation It may be concluded that section of the pallidofugal fibers (carried out in five instances) is attended with too many by-effects for the procedure to be offered as an operation of choice in the surgical treatment of parkinsonism As stated, it appears highly probable that removal of parts of the basal

ganglia has no direct effect on tremor or rigidity Subsequent to Meyers induction into the Army it was decided to pursue what seemed to me the most fruitful course, namely, interruption of the fibers of the anterior limb of the internal capsule It seems appropriate at this point to outline some of the technical features of the procedure as now carried out

### Procedure

The operation should be conducted under novocain infiltration without preoperative medication The subject is placed on the table in a supine postion and the drapes so arranged as to give a clear view of the extremities contralateral to the mode of the brain to be surgically exposed tremities should not be restrained or otherwise encumbered, especially the upper one A small box flap is outlined and turned down in the frontal region, fashioned to expose the falx and the upper frontal area. After reflecting the dura and gaining proper orientation, a 25- to 3-cm incision is made in the cortex anterior to the premotor area and 3 cm from the falx which it parallels The incision is carried into the most anterior aspect of the lateral ventricle, thus exposing the head of the caudate The upper half of this structure is removed either by suction or scoop, thereby exposing the inner fibers of the anterior limb of the internal The most anterior of these fibers curve in capsule rainbow fashion from forward aft to enter the cap-Using a blunt right-angle hook, the arm of the hook being 0.8 cm in length, section is begun at the rostral end of the capsule It is best to section about 1 to 2 mm of the capsular fibers at a time, then wait two to three minutes During this rest period the surgeon himself makes observations regarding the amplitude of the tremor of the contra lateral hand and the grip power is recorded Slowly, bit by bit, from forward toward the knee of the capsule the fibers are sectioned and observations as sug gested are made and recorded As a point approx mately 1 cm anterior to the knee of the capsule 18 approached, the patient not infrequently becomes difficult to arouse and only after rough prodding is he capable of cooperating After five to ten minutes this drowsy state passes and the tremor which usually abates during the drowsy period once again Further sectioning of the capsular becomes active fibers, up to a point approximately 07 to 08 cm. from the knee, completely abolishes the tremor This is not the end point of the operation. If further sectioning is not carried out the tremor usually returns within a few weeks after operation. It, therefore, is important to carry the sectioning further and the operation is completed only after the production of a marked paresis of the hand. In other words, the patient is just able to elevate the upper extremity from his side and is capable of only slight flexion of the fingers without being able

hemostasis, the wound is closed in the usual manner with layer silk Immediately after operation the extremities affected by the procedure are paretic and relatively flaccid, Babinski's sign and the so-called confirma-The abdominal reflexes are tories are present abolished on the involved side The patient usually is drowsy but easily aroused and cooperative. On the day following operation the hemiparesis often is more severe, gross movements of the paretic part, however, being preserved There is a tendency for the patient to "sleep" if left undisturbed Foods and fluids are taken readily Excessive sweat-

to grip the observer's hand Examination of the

lower extremity at this time will show that this

part is about as paretic as the upper

sign is easily demonstrable

Babınski's

Following complete

hing may be evident and this bilaterally A mild splegree of fever persists for a few days, but hyper clubernic states have not been observed. Occa whomally, there is a transitory period of an infantile grappe of micturition as sometimes is seen in other stypes of frontal lobe damage. Gradually, the motor appower returns and by the tenth to twolfth post-ciperative day when the patient is allowed out of bed, are mild to moderate hemiparesis is demonstrable splently and to moderate hemiparesis is demonstrable splently to perform skilled acts with the splently had been a forced to grapping been observed. A slight but evident hemic paresis persists in most subjects but this is not sufficient to cause inconvenience or clumsiness in the swe of the affected hand

#### Results

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During the past five years, 13 patients with parkinsonism have been subjected to this procedure An attempt has been made to standardize the operation. Eight of these 18 patients had what had been termed unilateral tremor and rigidity however in each instance there were findings indicative of slight involvement of the extremities of the "nor mal" side The results following operation were considered good in 6 of these 8 patients. The tremor was abolished, and rigidity was reduced markedly without more than minimal evidence of dyspraxia. In fact about four to six weeks after operation the hand was used with greater facility than in the presonce of tremor and rigidity before operation. In each of the 6 patients Babinski's sign could be demonstrated on the affected side postoperatively and under emotional stress there was in some, transitory rhythmical tremor of the upper extremity The mask-like facies in each was considerably improved in that there was more animation during speech. In most instances the speech remained slow and monotonous The gait in 4 of those 8 was considered normal, whereas in the other 2 there was slight spasticity associated with a mild limp In addition two of these 6 patients had oculogyric crises which were abolished by the operation. Two others in the series of 18 were considered im proved. They were free from tremor at long intervals but the rigidity component had not been appreciably altered by the operation.

The remaining 5 patients had obvious bilateral parkinsonism of many year's standing. In 3 of these the disease was manifested by marked rigidity and minimal tremor All 3 died as a result of a unflateral operation, one on the fourth one on the eighth, and the third on the eleventh postoperative The findings at autopsy in 2 of these failed to disclose an 'obvious cause for the fatal outcome The remaining 2 with bilateral features of the discase were submitted to unilateral operations. Tremer was abelished and rigidity was favorably influenced in each case however it is questionable whether cossation of tremor and modification of rigidity in the extremities of one side have benefited the situation as a whole. Up to the present time I have not carried out section of the capsular fibers bilaterally Theoretically bilateral operations of this magnitude should not be performed. Future experiences may prove this idea incorrect

For some as yet unexplained reason, patients with rendity as the outstanding manifestation of parkinsonism tolerate poorly the unilateral operation of capsular fiber section. Our experience with this particular group has caused us to exclude them temporarily as possible candidates for operation In fact, satisfactory results have been attained only in patients with gross rhythmical tremors of the one side. Operation may be per formed on the dominant hemisphere, however, speech will be impaired somewhat for four to six weeks after operation The removal of the upper half of the head of the caudate nucleus for the exposure of the capsular fibers does not alter either tremor or rigidity. Moreover, this plus the removal of the oral third of the putamen in one in stance produced no demonstrable changes.

Recurring convulsive seisures may follow any operation that anatomically alters the cerebral cortex. The transventricular operations herein described are no exception to this generalization Eight of the 25 patients upon whom a transven tricular operation was performed had one or more convulsions during the postoperative course. Only 2 continued to have recurrent fits after leaving the hospital and one of these has had only four such attacks in a three-year period

Fortunately many patients with tremor and rigidity of parkinsonism accept their disabilities and earry on their way of life in a productive and otherwise creditable manner. They should be encouraged to continue their activities and are not to be imbured with the notion that all their symptoms can be corrected by a surgical procedure. Some so afflicted refuse to accept any part of their handleap, discontinue all social and gainful activities and eventually scarcely can be persuaded to leave their own room. Such abnormal psychologic reactions may become a major feature of the disease and therefore must be evaluated accordingly.

Another group of considerable proportion having this disease seek relief at an age which in itself makes any elective surgical procedure inadvasable. The physiologic age of 50 arbitrarily has been set by me as the upper limit, however, many at 40 years of age with advanced parkinsonism should not be subjected to operation. If the physiologic age of 50 is adhered to strictly as the upper limit of operability then most instances of parkinsonism due to primary arterial disease will be excluded. All of the 25 patients in this sense operated upon by Meyers or myself were under 45 years of age.

Statements have appeared in the literature that leave the reader with the impression that parkins somem may be cured by surgical therapy. Certainly this is far from the fact. To me, improvement following operation is nothing more than

town called "aggression" is produced, and the amount produced depends upon the degree to which the need for defense is felt. Infants and children are particularly vulnerable, considerable immunity can be acquired, but prevention will always have more possibilities than cure.

We are at present attempting to prevent pandemics of war by group means We know that they will recur while the causes remain un-Perhaps we can gain much by individual case study, we have noted that as men become more free the tendency to aggression is Perhaps medicine is better equipped to deal with the problem than any other group cine is already world-wide in its scope, and has impressive victories in overcoming scored scourges that once devastated the world nox came under control because Edward Jenner as a country practitioner applied the results of his observations to one patient

For effective psychotherapy, as for any treatment, the foundation must be accurate understanding of the condition being dealt with most potent diagnostic means physicians have in psychiatry—perhaps in medicine, too—is a well-taken history To obtain this, we need to win the confidence of the patient, we need to listen and encourage spontaneous telling of the patient's story, and when questioning is needed, we need to know what to seek and how to interrogate This takes time, but it is time well invested time is not spent in careful investigation so that early treatment can be instituted, it will be wasted in ineffective and unsatisfactory contacts Many neurotic patients give a history of treatment by one doctor after another-sedatives, vitamins, endocrine products, physiotherapy, and reassurance have been given—but a psychoneurosis is a condition in which physical or nervous symptoms are an indirect expression of some difficulty of personal adjustment Careful study should disclose that difficulty and treat the source of symptoms instead of the symptoms The physician should make a carethemselves ful and thorough investigation of the man who is sick as well as the sickness the man has, and then try to help him work out his personal problems and conflicts

Direct observation and questioning give us a picture of our patient as he is. Our purpose in taking a history is to develop a dynamic understanding of his life so we understand the personal evolution by which the present condition was reached. If we do not have this knowledge, we are like the person who comes to a movie halfway through and sees two men fighting. He knows they are fighting, but has no idea what the fighting is about

There are three main parts to a psychiatric his-

The first is the patient's account, as much torv as possible given spontaneously, of his difficulty We can learn as much from how he says it as from By allowing time for free expreswhat he says sion before questioning, we learn much of the values the patient places on different parts of his Such an initial interview should not be storv hurried-forty-five minutes or an hour-with the doctor's chief effort directed to using his ears and not his tongue The second part consists of rebuilding the personal atmosphere in which early and later development of personality took place The influence of parents and home conditions is The family physician has the advery strong vantage of knowing some of the background al-We are often far too cursory in our inready quiry into family history In one case referred to me, the family history was listed as "negative," the father having died of peritonitis at the age of 49, ten years previously More careful question ing revealed that the peritonitis resulted from a gunshot wound inflicted by police in a gun battle when the father was staging a hold-up, and the patient had witnessed this in the village street. A family history is not a recital of "Father-55a & w, Mother-d 54 diabetes" It is the determination of the experiences the patient had in relation to those who helped-or sometimes did not help-his start in life, and his subsequent dealings with them In a recent consultation where surgeons had recognized a neurotic basis for complaints of a patient referred in for abdominal operation, the family history was listed as "negative" The patient's parents had separated before she was born, her mother refused to take care of her, she was placed in a foster home, and her foster-father committed suicide when she was This simply reminds us of the old medical "There is more missed by not looking saying than by not knowing "

The third part of a psychiatric history is per Knowing the general background and the people of most importance in it, a systematic account of the patient's life can be obtained are some things patients will tell readily, some they will tell after confidence has overcome reluctance to divulge intimate matters, and some which will come to the patient's consciousness dur-If we do not listen, ing the process of treatment we will not hear any of these If we are not trustworthy and tactful, we will not hear the second If we are not patient and understanding, we will not hear the third Yet the deeper maternal is the most valuable, diagnostically and therapeutically

What has just been said about the doctor's attitude determining the extent to which the patient reveals inner difficulties brings us to the point that psychotherapy has already begun when we start investigation. It is not therapy as we construe it pharmacologically or surgically, it is not done with needles or lights or massage. The physician himself by his own interest, maturity, and understanding is the therapeutic agent. For psychotherapy is personal influence therapy. It is simply the development in a more comprehending way of the doctor's old function in helping his patients through their personal difficulties. What the patient needs and seeks is a wise friend and counselor, one who will respect confidences, not embarrass or laugh at him, one who will help him find a way out of a maze of difficulties and teach him how to avoid getting into such trouble again.

Psychotherapy of the psychoses and severe psychoneuroses is a matter for those with specialist training, as major surgery belongs to the surgeon. There is a great deal of what we might call minor psychotherapy which can best be done by the family doctor. When investigation has indicated that trouble is not too deeply seated, he can proceed with confidence to help the patient to help himself.

Weir Mitchell once and that the most important prescription a doctor ever gives is advice. This is a form of psychotherapy, and since the physician has prestige and is trusted, his prescription is likely to be taken. Advice, however, is a very potent medication, and unsound advice can have decidedly harmful effects. It should never be given lightly, and always the probable effects of the advice it taken should be fully worked out. The best form of advice is that in which the patient works out with the help of the doctor his own idea of what is wisest for him to do Our function is that of a catalyst, not a reagent.

It is not possible in this short presentation to discuss the many ways in which the physician finds himself called upon to give advice. He will be consulted about health and personal relations, marriage, sex, and many other matters, some are quite remote from the medical field and need to be referred to others. But very often behind a seemingly physical complaint there is a desire to be able to talk with the doctor about something personal.

For example a 20-year-old girl went to her doctor frequently for six months and then when her turn came coughed and asked for cough medicine. Finally, she went to another doctor and told him the cough was just embarrassment, she had made an attempt to get away from a quarreling home atmosphere by means of an immature love affair, had an abortion which intendied her personal conflict and the resented attitude of her family to her, and she felt her doctor was the one to go to. When she went, she felt he would not understand because he did not listen to her

In directing our attention to early recognition

and prevention we logically must pay great attention to infancy and childhood. Already there is a great deal being done by general practitioners and pediatricians in child guidance. After reassuring ourselves that a child's symptoms are not primarily organic, we are now looking for some form of reaction to those who are entrusted with his care. Children grow better in a happy home than in a quarreling one, we need to help in the resolution of marital difficulties. Well-inten tuoned parents often are very ignorant of child development and how to guide children in their growth, we need to blend this information with the physical care in which we instruct parents There is no need to catalogue the many ways in which this type of help is sought or given, but it is important to recognize that this represents a most significant contribution to the prevention of later maladjustment.

Psychoneuroses are substitutive reactions, the physical or nervous symptoms are "stand-ins" for some difficulty in adjustment. The patient comes with stomach-ache or insomms or heart pounding or unreasonable anxiety about health, logically he comes to his doctor and the latter in vestigates his physical condition. Differential diagnosis must be made between similar symptoms of dissimilar origin, as, for example, between vomiting as an expression of appendicutis and an expression of disgust.

Disproportion between complaint and organic findings may suggest neurosis, but diagnosis by exclusion alone is not enough. The patient does not want to know what is not wrong he wants to know what is. We have already discussed the value of history-taking in ascertaining what the adjustment problem is. Psychologic tests are giving us laboratory procedures of growing value in diagnosis, prognosis, and treatment. New in sight into the deeper function of personality has been gained through hypnesis, narcosynthesis, and psychoanalysis. The two former are being discussed in the next paper

Physical investigation should not be curtailed because neurotic difficulties exist. One patient who was referred to the psychiatric clinic with digestive complaints had not been x rayed because of the neurosis, he had a duodonal ulcer. Soven years before he had tried to "help" a girl who was pregnant (though he had nothing to do with her being so). He had taken her to an abortionist, and the girl died twelve days later. For two years he went round inwardly accusing himself of murder, and then his digestive symptoms had appeared. Obviously only a psychosomatic approach can cope effectively with such a case.

We often find neurotic patients in situational difficulty, but outer troubles of themselves do not produce neurosis. I am often in situational difficulty on the golf course, and if you put my ball back on the fairway for me I will soon be in trouble again The expert can get out of trouble much better than I can, but he does not often get into the predicaments I do So with our neurotic Their difficulties are there, but somepatients thing within themselves helped get them there, and if we simply remove them from their home or marriage or job we accomplish virtually nothing, we need to help them learn how to play the game of life better, to keep on its fairways, and if they do get in its rough or its bunkers to extricate themselves quickly

The terrific situational stresses of war led to neurotic reactions in many who were well enough organized to have gone through civilian stresses in comfort Less acutely in civilian practice we see "situational neuroses" If the physician detects these as substitutive reactions he can obtain results quickly He should detect the anxiety behind the patient's complaints and seek to determine its source. In contrast to "situational neuroses," but chiefly in matter of degree, are those in which insecurity of relation to others is longstanding, and robust personality organization did not take place to any workable extent in There treatment is likely to be a earlier life long-range process and is generally a matter for the psychiatrist

The medical profession cannot ignore the disastrous results of missed diagnoses and mappropriate treatment of psychiatric disorders need to recognize the chronic invalidism that the unresolved psychoneurosis represents, and to note the frequency with which operations, heavy sedation, irrelevant medication, and superficially conceived advice have complicated the difficulty while the basic process has continued unchecked We must recognize the serious fallacy of the statement, "There's nothing wrong with you" or "It's all your imagination" Several years ago a depressed business man went to his doctor and was told after a physical examination there was nothing wrong with him-to go away and forget He went away and shot himself patient is within half an hour of threatened death from hemorrhage or shock we do not take it We need to develop an equally sensitive diagnostic conscience for psychiatric disturbances as we have for organic, and to study our errors in diagnosis and treatment carefully so that sımılar mıstakes do not recur

These are but a few aspects of a subject of great clinical and practical importance The need for psychiatric service to the community is great and urgent, the small number of specialists we have is grossly unequal to the demand We must train medical students during their course, we must develop psychiatric services in general hospitals where interchange of knowledge between internist and psychiatrist can take place readily, we must make postgraduate instruction available for those who recognize the need but have not had the basic training

Medicine has tackled some formidable problems before and come out the winner triumphs over smallpox, typhoid, and diphthena should give us confidence that we can meet this challenge and win again As we reduce and finally prevent the tragedies that we call mental and nervous diseases, we will be equaling and perhaps exceeding any of the greatest victories man has yet achieved in his long struggle with the ills that beset his kind

## 'I HAVE LOST A FRIEND"

Last week a man stepped out of this world to explore the multiverse and that adventure along the trail where the immortal souls of men travel

In this life, he was unveeringly honest and frank with himself Being of this sort, he was without pretense and the counterfeits characteristic of so many of those who live by expedients and strate-Yes, we shall miss his friendship

time of parting, we pause and think.

How far we of the medical profession could go in meeting the challenges which confront us in this era of social unrest if each one would so order his ways of life that at the time of demise all who have received care at our hands would say, "I have lost a friend"

Have we modern doctors in the zeal for better methods lost the human touch of friendship for those we serve? Meeting the financial obligations incident to medical care is often as much of a problem to the patient as recovery of health itself. If we turn an intellectual "blind spot" upon this phase of the patient's life, we may be fulfilling our duty as doctors, but we fall short of being "a freed". friend.'

The whole modern world needs something more friendship perhaps We're sure a little friendship added to the science of medicine would give it that soul and public good will which it had in the days of our horse-and-buggy grandfathers -United

Medical Service Bulletin, October, 1947

## HYPERTHYROIDISM ITS DIAGNOSIS AND MEDICAL OR SURGICAL TREATMENT

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NOW that antithyroid substances are avail able for the medical treatment of certain able for the medical treatment of certain thyroid gland diseases,12 it is more important than ever before to diagnose true hyperthyroidism accurately and to differentiate it from conditions that may simulate it. Medical treatment of disorders of the thyroid gland is not applicable in all cases, and, therefore, has not replaced and cannot replace surgical therapy completely Sound judgment must be exercised in selecting the proper form of treatment for each patient who suffers from hyperthyroidism, but before this is possible it is of even greater importance to differen tiate this disease from symptom-complexes, the clinical manifestations of which simulate thyrotoxicons.

Mild neuroses are more frequently confused with hyperthyroidism than any other group of clinical disorders, and since patients who suffer from these conditions may also have slight colloid hypertrophy of the thyroid gland it becomes imperative to differentiate these neurotic states from true hyperthyroidism in order to prevent needless operative or medical treatment.

It is common practice to rely upon the determination of the metabolic rate to establish a diag nosis of thyrotoxicosis. Unfortunately, this test has so many sources of error that, more often than not, it is musleading, and it is our belief that many more accurate diagnoses would be made without the confusing result of this unreliable The determination of blood cholesterol and of blood iodine is also subject to many errors and these tests cannot be relied upon completely There is no laboratory test or group of laboratory tests capable of establishing a diagnosis of hyperthyroidism. As far as we know the most reliable means of making an accurate diagnosis is the correct interpretation of a detailed history and a carefully made physical examination.

To understand the variations in the history that are of differential diagnostic importance the examiner should remember that hyperthyroidism is a metabolic discose that produces organic changes twenty four hours each day. It is a discose characterized by remissions, but these do not occur in a matter of hours or days, as do variations in the neuroscs. Unless the history indicates that heightened metabolism has truly affected the various body functions the diagnosis of hyperthyroidism should be kept in reserve.

Of importance diagnostically is the relation ship of food lutake to weight change While it is true that young patients with severe hyperthy rodism can eat enough food to cause a gain in weight, this excessive intake is apparent from a history of frequent feedings of large quantities of food On the other hand a poor or average appetite and a weight variation of only a few pounds is strongly against the presence of hyperthyroidism

Increase in the body's metabolism causes the production of heat that must be disripated to maintain normal body temperature. Dilutation of the subcutaneous capillaries results and is apparent in the flushed, warm skin of these patients who cannot tolerate much external heat. Generalized hyperhidrosis is also associated with heat intolerance. When the history indicates that only axillary perspiration is present and especially when associated with elammy cold hands, the diagnosis of hyperthyrodism is in doubt. The answer to the question, "Do your hands feel warm or cold to you?" gives the most valuable single clue to the diagnosis.

Tachycardia is common in hyperthyroidism. It tends to be constant and continuous. If it is mermittent this finding is opposed to the diag nosis of overactivity of the thyroid gland. Consciousness of one sown heart action varies in individuals but if there are days in which the patient notes no tachycardia it is evidence against the presence of hyperthyroidism.

Because of the extreme metabolic drive of the disease the patient with hyperthyroidism tires quickly. She begins the day full of enthusiasm and good intentions but soon must give in to physical limitations. In contrast to this is the patient who suffers from nervousness not due to thyrotoxicosis who arises thred in the morning but who frequently improves during the day and actually feels better toward evening.

The onset of noticeable variation in such symptoms as nervousness, irritability emotional instability menstrual flow, dyspinea, and gastrointestinal complaints is of importance when present. They are less reliable as aids in the differential diagnosis because of their greater variability even in patients with hyperthyroidism.

On physical examination palpation of the thy rold gland gives the most important information. The thyroid gland of hyperthyroidism is so firm that it is sharply demarcated. It may be small but the solidarity of hyperplasia is so characteristic that with but little practice it is readily recognized. When this typical, clear-cut firmness is associated with thrill and bruit over the superior thyroid arteries, the diagnosis of hyperplasia and overactivity is established. If, on the other hand, even though it is slightly enlarged, the gland is soft and elastic, this finding is contrary to the diagnosis of hyperthyroidism.

The characteristic elevation in pulse pressure, the sharp precordial slap of the heart overworking from thyrotoxicosis, the palpable muscle tremor, and all of the eye signs are useful, if they are pres-The absence of these signs early in the course of the disease is not incompatible with a diagnosis of hyperthyroidism if other reliable evidence is positive If, however, the diagnosis is in doubt, it is reasonable to prescribe a mild sedative and then to observe the patient over a period of several weeks during which hyperthyroidism will become more apparent, while disease of nervous instability will vary but slightly or may actually Such a period of observation is not disadvantageous for the patient at such an early stage of the disease as long as the observation interval does not exceed one month peutic use of rodine, given as Lugol's solution, may be justified in carefully selected cases, but it is better to withhold iodine until the diagnosis is established and the treatment outlined

When a diagnosis of hyperthyroidism is finally established the choice of medical or surgical management must be made The authors recognize that there is an increasing trend toward the use of medical therapy, but they urge that the needs of each patient be evaluated carefully before the method of treatment is decided upon Winkle and his associates feel that antithyroid drugs are contraindicated in the treatment of simple or adolescent goiter 5 Cole feels that these drugs are madvisable in the treatment of so-called thyroid crisis 1 There is evidence to indicate that the purely medical treatment of large, toxic, diffuse goiters will not be successful If the gorter is nodular another element must be considered, namely, that of possible malignant change We believe that all nodular goiters should be removed surgically as a prophylactic measure against the development of such change 5

The addition of antithyroid substances has enabled more prolonged, and, therefore more adequate, preparation of the patient for surgical removal of a portion of the thyroid gland with a resulting mortality rate from thyroidectomy which is caused solely by uncontrollable vascular accidents. We do not subscribe to the overenthusiastic claims that thiournal and its derivatives will replace operative intervention in the treatment of all forms of hyperthyroidism. It becomes self-

evident that these drugs cannot replace subtotal thyroidectomy when their site and mode of action is understood, for it now seems established that thiouracil acts on the thyroid epithelium to prevent the synthesis of the thyroid hormone. The most widely accepted theory of the caus of exophthalmic goiter is that the thyroid glan responds to some stimulus which arises outside this organ. It must follow that neither the medical nor the surgical treatment of the disease attacks the real cause of the glandular overactivity and, therefore, failures of both methods of treatment are inevitable.

Thyroidectomy, performed by men of experence today, results in 90 to 95 per cent permaner remissions of the symptoms of hyperthyroids with a mortality rate of well under 1 per cen. The cause of the disease, as is the case with medical treatment, is not eliminated. In contras permanent remissions resulting from the medic treatment have yet to be established and the motality rate is comparable to that caused by sugery

It seems, however, that at least one half of t patients treated with antithyroid drugs a greatly benefitted and may obtain a permane remission Employed with judgment at understanding, then, throuracil and its derivativ benefit at least half of the patients receiving the and when used to prepare patients for surgic treatment, they have increased the safety For a selected for operation for many patients these drugs make an operation avoidable form of these antithyroid drugs, soon to becor commercially available, is 6-propyl thiouracil, which has proved experimentally to have a much lower incidence of toxic reactions than thiouracil 10 Nevertheless, this new drug has caused toxic manifestations in 2 per cent of the cases and its indiscriminate use in patients who do not have true hyperthyroidism may actually be disastrous

At the present time we are using this new compound\* to prepare all bad risk patients for surgical treatment, especially those who have complicating diseases. Patients who refuse operation are treated with the drug as are a few selected cases who present hyperthyroidism with small thyroid glands. In this latter group the probable duration of treatment and the uncertainty of permanent cure are explained to the patient so that there is no dissatisfaction and no reverting to operative treatment in the middle of the medical management.

Our total experience with this method of medical treatment is short when compared with many

<sup>\*6-</sup>propyl thiourneil, used in this study was supplied through the kindness of Lederle Laboratories Division American Cyanamid Company, New York City

others who have had an opportunity to use these drugs since their first announcement. For over one year we have been using 6-propyl thiouracil in average doses of 200 mg, per day Thirty pa tients have been so treated and there has been no instance of granulocytopenia. Two patients complained of frequent micturation and one patient of nausea but the drug was not stopped in any of these cases. Six patients were operated upon without difficulty after preoperative preparation with propyl thiouracil and iodine patient has completed a course of treatment and remained symptom free for four months and an other patient has similarly remained symptom free for two months. The remainder of the group are still receiving treatment.

Surgical treatment of recurrent hyperthyroidism is much more dangerous for the patient and is usually more difficult for the surgeon. To this group of patients, propyl thiourneil offers an opportunity to avoid further operation and, thereby to escape from the increased hazards of secondary operations. Four patients in our group are being treated medically for the recurrence of their

hyperthyroidism.

Today, it is becoming more and more common for one who sees many patients with thyroid disease to observe an increasing number of cases treated with some form of medical therapy large a number of these patients do not have symptoms that are caused by their thyroid glands! This fact plus our own expenence with 6-propyl thiouracil leads to the following conclu-

Careful analysis of the symptoms and a careful physical examination will establish a diagnosis in almost every patient. Accurately ascertaining the presence of true hyporthyroidism will prevent the induscriminate use of drug therapy in patients who do not have thyroid gland disease.

2. Thiouracil and its derivatives have reduced the already low mortality from thyroidectomy and they have made it possible to operate upon

extremely bad risk patients.

A few patients, carefully selected, may have a permanent remission produced by medical treatment with these druck. Operative removal is still the treatment of

choice in all nodular goiters

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1946

#### THREE DISEASES CAUSE 80 TO 90% OF ALL CASES OF HYPOGLYCEMIA

Eighty to 90 per cent of all cases of hypoglycemia, an abnormally low level of sugar in the blood, result from three diseases which Jerome W Conn M.D. of Ann Arbor, Michigan, defines so that treatment

may be more successful.
Writing in the May 10 issue of the Journal of the American Medical Association, Dr Conn differen

trates the three types as follows

Functional hypernsulinism is caused by over-secretion of insulin in the pancreas. Insulin trans-forms carbohydrates for body use but its over production deprives the blood of necessary sugar Symptoms are weakness irritability fatigue, sweating and dizziness. This type is not progressive in severity. It occurs more frequently under amotional or physical tension which acts as a stumulus. Hypoglycemic attacks occur two to four hours after meals. Dr Conn found that a high protein low earbohydrate diet is successful in the management of this type of hypoglycemia. Organic hyperinsulinism is caused by the growth

of a tumor or tumors in the pancreas which stimu-

late the production of insulin.

This type is progressive in frequency and severity of attacks which occur before breakfast from two to eight a.m and two to four hours after meals. The attacks are precipitated by skipped or late meals or exercise. Removal of these tumors results in complete alleviation of the entire disturbance without recurrence in the vast

majority of cases.

The third type hepatogenic hypoglycemis, as traceable to changes in the liver This organ is responsible for the storage of glycogen which is converted into sugar as the needs of the system require. However if this storage does not take place because of some condition such as a diseased gallbladder then the body is deprived of its needs. This type of hypoglycemia is also progressive in frequency and severity with attacks occurring before breakfast. These patients should be put on a diet both high in carbohydrate and high in protein

## PROBABLE NASAL DIPHTHERIA, WITH OBSERVATIONS ON SCHICK TESTS

Joseph S Fribush, M D, New York City

W/ITH the rising incidence of diphtheria noted by observers in Europe, Nova Scotia, and upstate New York,1 this case is reported, along with observations of Schick tests performed in private practice, in order to focus attention on the eternal vigilance necessary in the fight against this disease While nasal diphtheria is today an unusual form of infection, it was well known thirty years ago as described in 1913 by McCollum and Place <sup>2</sup>

S G, a 41/x-year-old white boy, was seen on October 5, 1946, because of a purulent discharge from the left nostril This had been present intermittently since August, 1946, at which time he had been in camp Sharing the same bunk with him at that time was another child who had a prolonged, untreated rhinitis of unknown cause

The left nasal discharge was noticed first sometime in August, but had cleared up spontaneously and then recurred in October There were no systemic manifestations observed except for some loss

of appetite

The past immunization history was as follows

Three injections of 1 cc each of plain diphtheria toxoid at 9, 10, and 11 months of age

2 May 24, 1945 Schick test positive, control

negative 3 June 9, 1945 1 cc alum precipitated diphtheria tetanus toxoid September 29, 1945 1 cc alum precipitated diphtheria tetanus toxoid

No repeat Schick test was done

Physical examination revealed a thick mucopurulent discharge from the left nostril and the presence of a thick, yellowish membrane extending from the floor of the nose up along the lateral wall. This membrane bled when an attempt was made to remove a portion of it The remainder of the physical examination, including temperature, was normal except for residua of mild rickets and some pallor A culture was taken immediately and sent to the Health Department which reported it positive for diphtheria bacilli The next day another culture was reported positive and a 12,500-unit dose of antitoxin was given intramuscularly

Schick tests on the mother and the 9-year-old sister were negative, while the father had a positive Schick test with negative control Nasal cultures from mother, father, and sister were all negative These nasal cultures were again all negative on Oc-

tober 16 and November 1, 1946

The child received local therapy by means of penicillin in saline drops and nasal packs of this same material On October 12, 13, and 14, the nasal cultures were negative. By October 13 the membrane had receded markedly until only a small patch remained on the floor of the left naris and local penicillin therapy was stopped At no time were any systemic manifestations of toxicity observed. The child's appetite improved and he behaved like a normal boy

On October 16, the nasal culture was negative but a throat culture taken for the first time was positive On October 18 and 19 both nose and throat cultures On October 20, however, both nose were negative and throat cultures were reported positive for diphtheria bacilli In the meantime the child had received no furthur therapy, and it was noted that the membrane had recurred and was almost its original

At no time was a sanguinous discharge ob-

served, nor did he ever appear sick

From October 26 to October 28, Paredrine-sulfathiazole was used locally in the form of drops and packs With the report of a positive throat culture, however, on October 28, it was decided to attempt intramuscular penicillin in beeswax and oil cubic centimeter (300,000 units) of this preparation was administered daily for six days. This resulted in a marked diminution in the membrane, although a small grayish-white patch could be seen on the floor of the left nostril about one-half inch inward

Examination of the nose on November 2, 1946, revealed no foreign body A slimy, sticky mass of grayish-white mucus was sucked out from the floor of the left nostril, leaving a small ulcerated area beneath it. The Schick test on November 5 was negative, the blood count revealed a mild iron deficiency anemia, and the electrocardiogram showed no dis-turbances in the conduction mechanism

On November 4, 1946, after the child had been discharged by the Health Department because of two consecutive negative cultures of the nose and throat, the culture of October 26 was reported as avirulent

### Comment

Whether this case could have been considered truly one of anterior nasal diphtheria depended entirely on the virulence of the organism isolated at the onset of the disease The routine procedure of the New York City Health Department is to perform such virulence tests only after twenty-one days have elapsed from the original positive culture In the meantime, with the clinical picture as it presented itself, I felt justified in immediately instituting antitovin therapy Such, I believe, is the wisest procedure in the vast majority of similar situations Would it not be advisable, however, routinely to perform virulence tests on all positive diphtheria cultures originally, while concurrently administering antitoxin immediately? Most cases of diphtheritic involvement of the nose recorded in the literature (Kane, 3 Stux4) occur in infants in whom usually there is no previous immunization However, Neubauer reports 50 cases of all types of diphtheria occurring in inoculated children Gibbard et al reported 23 cases in fully immunized patients and observed that no deaths or serious illness occurred among them 6

The use of penicilin was based upon the work of Skinner who reported that of 25 patients receiving 50 to 100,000 units of parenteral penicillin daily for repeatedly positive virulent intermedius type throat cultures, 16 became negative 7 From a theoretical standpoint, it is conceivable that a virulent diphtheria bacillus may be converted into an avirulent form as the result of treatment, although most cases

become negative following antitovin

## Personal Experiences with Shick Tests

Of a series of 128 children who received Schick and control tests, 9 cases were found to be positive Every one of these 9 had negative control reactions

TABLE 1 -POSITIVE SMICK TESTS

Age	Bax	Primary Immunization	Time After End of Primary Immunization	Secondary Immunication	Repeat Schick Tast
				Alum precipitated diphtheria	,
1/1 years	P	? Plain toxold	21/1 years	Alum precipitated diphtheria	Negative 8 months after last
1/2 years	M	Piain toroid—3	11/s years	Alum precipitated diphtheria	Negative 4 months after last
1/1 years	F	Plain toxold—3	8 months	None	
	F	1	2 years	tetanus—2 Alum precipitated diphtheria	last does
1/1 years	P	Plain toxoid—8	7 months	totanus—2 Alum precipitated diphtheria	
1/1 years	P	None Plain toroid—2	)	Perdipigen fiuld—3 Alum precipitated diphtheria	
	il/s years il/s years il/s years il/s years il months il years	years M  il/s years F  il/s years M  il/s years F  il months F  years F  il/s years F	Age Bax Immunisation years M Piain toxoid—3 1/s years F ? Piain toxoid—3 1/s years F Piain toxoid—3 1 months F Piain toxoid—3 1/s years F Piain toxoid—3 1/s years F Piain toxoid—3 1/s years F Piain toxoid—5	Age Sax Primary Immunisation Primary Immunisation Plain toroid—3 2 years P Plain toroid—3 11/2 years P Plain toroid—3 8 months 1 years F Plain toroid—3 8 months 1 years F Plain toroid—3 7 years Plain toroid—3 7 months Plain toroid—3 7 months Plain toroid—3 7 months Plain toroid—3 7 months	Age Bax Immunisation Immunisation  Primary Immunisation Immunisation  Primary Immunisation Immunisation  Primary Immunisation  Prima

An additional 4 cases had combined reactions, namely positive Scheck and positive control. The wast majority of children were tested six months to two years after immunization had been completed and all were tested later than three months after the last immunizing dose

The distribution of the immunizing agent used was as follows plant toxold, 69 cases perdipigen fluid 35 cases alum precipitated diphtheria tota nus, 3 cases, alum precipitated diphtheria, 1 case

unknown agent, 14 cases.

Table 1 shows the significant data in each case with a positive Schick test. It is interesting to note that in no case of primary immunization was perdipigen used. However no definite conclusion can be drawn from this because of the small series of perdipigen immunizations. Three patients after a second ary immunization course were shown to have a negative Schick test.

Table 2 lists the combined reactions. Since the exact agnificance of a positive Schick test is obscured by the allergic control reaction, I feel now that it is wiser to relimination these children. This table also shows the value of the control test. Topely and Wilson describe the combined reaction as one in which the control test has faded considerably by the fourth day thus indicating a positive Schick test with an allergic reaction to the toxin substrate. They differentiate this from the pseudoreaction, in which both the Schick test and the control disappear by the fourth day. Teaving some alight degree of reddish or brownish discoloration.

An incidence in this series of 7 per cent positive Schick tests plus an additional 3 per cent incidence of combined reactions illustrates the utility of this test in private practice. These figures also indicate the failure of careful immunization to result in a negative Schick test in a small percentage of cases. Volk and Bunnev report that 7 per cent were not immune following three injections of fluid toxoid whereas they found only 2 per cent were not immune following two injections of alum precipitated tox

Schwarz reported his experiences with the Schick test in private practice and found the following 2

- 1 Of 150 children who received two doses of toxold and were Schick tested four to ten years later 22 per cent were positive
- 2 Of 77 children who received one dose of alum precipitated toxold, 16 per cent were Schick positive three to five years later
- No mention of control tests was found in his article Banjamin Fleming, and Ross using controls, reported 14.9 per cent positive Schick tests in 1 522 Montreal children tested five to eleven years after the third dose of toxoid <sup>11</sup>

The following conclusions are drawn from the above for use in private practice

- 1 All children should receive a Schick test and control three to six months after the last immunizing dose
- 2 If positive a secondary immunization course with alum precipitated diphtheria toxoid should be done and followed by a repeat Schick test.
- 3 A combined reaction should result probably in reimmunization without repeating the Schick test.
- 4 The Schick test should be repeated before entering school.

#### Conclusions

1 Every case of unliateral nasal discharge in any age group regardless of previous immunization history, should be cultured for the presence of diph theria.

TABLE 2.—POSITIVE SCRICE AND POSITIVE CONTROL TESTS

Name	Ар	Sex	Primary Immunisati n	Time After End of Primary Immunication	Secondary Immunication
1. R.G.	3 years	F	Plain toxold—3	2 years	Alum precipitated diphtheria tet
L E.G	2 years	F	Alum precipitated diphtheria tetanus	1 year	Alum precipitated diphtheria tet
8. K.O.	41/4 years	r	7	8 уевгя	None (covered with hivee the next
1 M. B.	11/ years	F	Perdipigen fluid4	9 months	day) None

- In atypical localizations of the diphtheritic membrane, it would be desirable to do a virulence test at the time of diagnosis Antitoxin, however must be given immediately in the presence of the clinical picture and a positive culture
- In private practice, the Schick test is demonstrated to be of great value and should be performed routinely

#### Summary

A case of probable nasal diphtheria occurring in a previously immunized child is reported along with personal observations on Schick tests in private prac-

1488 METROPOLITAN AVENUE

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### EXPANSION OF STATE'S HEALTH RESOURCES UNDERSCORED

In a talk before the annual meeting of the Fifth District Branch of the Medical Society of the State of New York in Utica, September 30, Dr Herman E Hilleboe, state commissioner of health, emphasized the need for expansion of the State's resources and extension of action along four major lines recruitment and training of professional personnel, expansion of local health departments and their services, vigorous pursuit of the challenges of program planning and enlargement of the scope of fundamental and applied research, and encouragement of the fullest cooperation between the local health officer and the general practitioner

He said in part "We must expand health services rapidly throughout the State and achieve a high level of efficiency Although the madequate resources of professional personnel-medical officers and public health nurses-make this task exceedingly difficult, we must go forward immediately to recruit promising candidates who can be trained to Long-range plans for training must to do the job be developed, but while such a process advances we must do all we can to increase the effectiveness of available personnel

"As health department programs become more inclusive, we must be on guard against too much centralization, we must work more closely among the people and bring health services directly to them in their communities and their homes through local health units, county and city, manned by welltrained professional people

"Now that the war is over we must review the program of every division of our health department with an eye to making whatever changes and improvements are necessary to provide the greatest efficiency and make available every possible public health service to our people. To accomplish this we will work closely with the Committee on Public Health and Education of the Medical Society of the State of New York

"The general practitioner and the full-time local health officer together are the basic elements of The former 18 curative and preventive medicine still the most important force in the control of disease in the community Participation by the private physician in the activities of the local health department must be stimulated and encouraged. The local health officers and the rural physicians have the sole responsibility of extending the frontiers of medicine in rural areas Therefore, we must have many more of both of them, and they should be within the geographic and economic reach of the people at all times

-Health News, October 13, 1947

#### FULMINATING MENINGITIS AND INTRATHECAL PENICILLIN

BTRON D ST JOHN M.D., Port Washington New York

28-YEAR-OLD white woman, was admitted A unconscious to the hospital on December 25, 1945 Her illness was given by the family and the

family physician as follows

On the previous day December 24 1945 the patient had had symptoms of an ordinary cold, but had felt well enough to go to a neighboring town to attend a family party. On rising the next morning, she had symptoms of a cold and at 11 00 a.m. had developed a slight headache, which went on quickly to nausea, vomiting, and difficulty with vision, and at 2 00 r.s. the family doctor was called. He found that she had a stiff neck, and made a diagnosis of meningitis. After giving her 5 Gm. of sulfadiazine by mouth, he sent her to the hospital. She was ad mitted unconscious at 4 00 P.M.

Part History -The patient was one month postpartum. She had never been ill, except for the usual childhood diseases, and there was no history of sinus infection or of outla media. The family history revealed that the mother father, and three brothers were living and well. The history by systems failed to reveal any important facts.

Physical Examination.—The temperature was 104 F., pulse 120 and respirations were 18. Lying on her left side the patient cried with pain when an attempt was made to turn her head to the right. She roused when spoken to loudly but did not obey commands. The pupils were small and reacted to light. There was no deviation of the eyes and no apparent nystagmus. The neck was very stiff The cars and nose were negative, throat was pink, and the tonsile were large. There were no cervical, clavicular or arillary nodes. The breasts were normal. The lungs were clear throughout. The heart showed the maximum apex impulse within the midelavicular line. No murmurs were heard. The aortic second sound equaled the pulmonic second sound. There was a regular sinus rhythm The ventricular rate was 120 The abdomen showed the abdominal reflexes absent, no masses, and no rigidity The skin showed no rash and no evidence of petechiae. The patient lay on her left side with her knees flexed. Neurologic examination showed a marked rigidity of the neck with a possible Babinski Abdominal reflexes were absent and

there was a positive hernig.

Progress Notes Laboratory Fundings and Treatment.—On December 25 at 4 30 p.m., a spinal tap was done. The initial pressure was 44 mm. of mercury and the final pressure was 10 mm. cell count was 13,700 and mostly polymorphonu clears. No organisms were found on smear or cul-ture. Blood was taken for a culture, count, and chemistry Routine examination of the urine was made. The patient was now totally comatose not

responding to any stimuli

The patient had been nek only five and one-half hours and was now moribund and of course, we realized that we were dealing with a fulminating meningitis of unknown etiology that almost surely would end fatally in the next twenty four hours. The usual dose of 20 000 units of peniclilin had been prepared to be given intratheonly but it was docided that, in view of the extreme rapidity of onset of these symptoms, we would be justified in giving a larger dose One hundred thousand units of penicillin were dissolved in 5 cc. of spinal fluid and were given very slowly by the intrathecal route, in jecting 1/2 cc. and withdrawing 1/2 cc. and, then, injecting 1 cc. and withdrawing 1 cc.

The amount injected was gradually increased until at the end of three-quarters of an hour the last of the fluid was given After the last cc. was injected, the patient suddenly became disturbed and thrashed about in the bed so violently that she had to be restrained and was given sodium amytal, Five Gm. of sodium sulfadiazine were given intravenously Stat., and 50 000 units of penicillin every three hours intravenously A Levine tube was passed through the nose to the stomach, so that the patient could be given sulfadiazine, 2 Gm. every four hours. This treatment was carried out through the night with constant restraint being necessary

On December 20 at 9 00 A.M., the temperature was 102 F and the patient was stuporous but did respond to painful stimuli and repeated questioning. She had a warm, dry skin, and flushed face. There was painful stiffness of the neck, and positive Kernig and Brudzinskı signs. The lungs were clear Blood culture and spinal fluid culture were negative. A spinal tap at 2 00 r.u showed a cloudy yellow fluid, initial pressure was 32 mm. of mercury, final pressure was 10 mm. Twenty-five thousand units of penicillin were given intrathecally 2 Gm. of sulfadiazine every four hours were given by mouth, and 50 000 units of penicillin, intravenously The report on the spinal fluid showed a cell count of 72,000 mostly polymorphonuclears sugar in a reduced amount, chlorides 648.5 mg, total protein 975 mg. The blood count showed 6,000 white cells with 94 per cont polymorphonuclears and 6 per cent lymphocytes, the unne contained a trace of albumin and many red cells. Blood chemistry showed a nonprotein nitrogen of 21 mg, per 100 cc. of blood reatinine 1.5 mg., blood stigar 190 mg, suifa level
12 mg., and a negative Kahn test. At 3 00 r m the
patient became conscous and answered questions
quickly and accurately Her temperature was 99.8
F by rectum. There was less neck rigidity and there was marked strablemus and nystagmus. An eye consultation revealed divergent paralysis with possibly some involvement of the left, sixth nerve.

On December 27 the nose and throat cultures were negative. The blood culture was sterile after forty eight hours. Spinal fluid culture showed no or ganisms. A spinal tap was done initial pressure was 12 mm. final pressure was 6 mm. Twenty five thousand units of penicillin were given intrathecally. The cell count of the spinal fluid had dropped to 6 300 with 30 per cent polymorphonuclears. The patient was given sulfadiatine, 2 Gm. every four hours by mouth. The urins report was negative On December 23 the patient was greatly improved No tap was needed.

On December 29 she had a severe headache. A spinal tap was done, with the initial pressure 13 mm. and the final pressure, 9 mm. 8 cc. of opalescent fluid were removed. The temperature was 100 F by

On December 31 her temperature was normal and all medication was discontinued. On January 1046, there was no nystagmus, squint, nor double vision. Her neck was not stiff The patient was free of all symptoms and felt fine There were no abnormal reflexes and the abdominals were still absent. On January 7 the patient was discharged home and there were no residual signs or symptoms

On November 11, 1946, it was reported that this patient had remained in perfect health since leaving the hospital and, at the time of this re-

port, was six months' pregnant.

Dr Clement Boccalini has now reported to me that she had a spontaneous delivery of a normal infant on February 26, 1947, with an uneventful antepartum and postpartum period

### Summary and Discussion

A case is reported of fulminating meningitis that was vigorously treated during the early hours of the disease with special attention to the large dose of penicillin intrathecally Speculations as to whether this patient, untreated, or less vigorously treated, would have had adrenal hemorrhages, shock, and death, as seen in Waterhouse-Friderichsen syndrome, are futile

Many deaths are reported in cases with similar onset and in cases with much longer onset of symptoms where no penicillin is given intrathecally Penicillin is probably not needed in the case of proved meningococcic meningitis, while in the case under discussion no organism was found

Often the clinical diagnosis of the meningococcic meningitis is made on the basis of symptoms related above, plus the typical rash, and the only remedy given is the sulfa drug because of the well-known efficacy of this antibiotic in meningococcic menin-This is a bad practice and not in the best interest of the patient, because all too often the laboratory fails to find the meningococcus, and valuable time has been lost before penicilin is started Therefore, it would seem that if the original examination of the spinal fluid sent to the laboratory for immediate examination fails to reveal any organisms, the patient should receive sulfa drug intravenously and orally, and penicillin intravenously and intrathecally, and if the symptoms are fulminating, the patient should receive extremely large doses of penicillin by the intraspinal route Streptomycin is rapidly gaining a position of importance in the treatment of meningitis

### 'DOCTOR JONES" SAYS-

Manners and public health did you ever stop to think how they hook up, sometimes? Or that health departments've been responsible for manners being

improved in certain respects?

How often, nowadays, do you see anyone spitting on the floor in a public place or even on the sidewalk? In fact, it's so seldom that the younger folks-it probably wouldn't occur to most of 'em that it ever could've been common enough to've been a serious

And yet, not over thirty-five or forty years ago, "No Spitting" signs were plastered all over the landscape trains, trolley cars, buses, trees, even in places like restaurants and theaters. And, even then, they had to have cops around to watch 'em Cuspidors were a regular part of the equipment in most public places—a good many private ones, too

Yes, I can remember when they had signs in the County Court House "Spit in the Spittoons" They made it direct and to the point, hoping the spitters'd do as well They tell me about the cop that was on duty and had his eye on a fellow sitting near one of the signs Finally he went over and poked him "Don't jez see that sign?" he says

"Well then," the cop says, The fellow said he did "why don't yez spit?"

It might ve been the beginning of the drive against tuberculosis that started the movement to stop promiscuous spitting. They figured the disease germs could be blown around in the dust and so on Now it's mainly a matter of good manners

Then, when we had the big influenza epidemic, in 1918, they decided folks coughing and sneezing in other people's faces was helping to spread the disease. And, of course, there's other diseases as well where the germs are in the mouth and nose discharges

Anyway, they began putting up illustrated plac-ds "Cover Your Sneezes" and so on That wasn't quite thirty years ago and, already, it's begun to dawn on a lot of people that keeping their coughs and sneezes to themselves—regardless of scattering

germs, it's just ordinary good manners And there's other stuations, not so obvious, where good manners and health hook up "evil communications corrupt good manners," so Meander, the dramatist, said—and the Apostle Paul quoted it They might've added and evil manners spread communicable diseases—Health News

#### MECHANICAL INTESTINAL OBSTRUCTION

BENJAMIN A SCHANIZ, M D, and RICHARD S KAMIL M.D, Middletown New York

(From the Maddletown State Hospital)

A LTHOUGH there have been numerous reports of various substances having been swallowed accidentally or deliberately, we believe that this case deserves mention because of the large amount of foreign material ingested and the protein symptoms which resulted No effort will be made to discuss the dynamics of the underlying per sonality except to indicate that the patient was suffering from a chronic dementia.

#### Case Report

The subject is a 35-year-old man who had been hospitalized in a mental institution for ten years with a diagnosis of schizophrenia, catatonic type Always a markedly retracted individual, devoid of spontaneous reaction, lacking responsiveness and almost mutistic, it was surprising that he should now complain of pain and discomfort.

Nausca and vomiting were conspicuously absent In addition to the subjective symptoms there were objective signs which warranted consideration. He had a temperature of 99.2 F, a pulse rate of 94 but no increase in respiratory rate. Blood pressure was 110/78. His abdomen was markedly rigid but it was the impression of the writers that much of this rigidity was voluntary Palpation over the stomach elicited exquisite pain which was particularly marked in the left lower quadrant Auscultation of the abdomen was difficult because of the continuous groaning by the patient but no bowel tones were hard. Rectal examination revealed tenderness upon stretching the pelvic peritoneum and, also most pronounced in the left lower quad rant. Roentgenologic examination was not available. A leukocytonis of 18,000 with 85 per cent polymorphonuclear neutrophils was obtained on blood examination.

Since it was known that the patient had a habit of ingrating foreign material such as blankets clothing, sticks, and the like a tentative diagnosis of small bowel perforation was offered.

Under a general anesthesia, a large parimedian incision of about 15 cc. was made. There was no exudate in the peritoneal cavity and the small bowel immediately came into view. It was noted that there was a solid rectangular mass at the ter minal part of the jejunum about 18 cc. in length. It exerted marked pressure on either end, producing areas of blanching where the pressure was noted at either end of the foreign part. A longitudinal incision was made in the small bowel and the mass re-

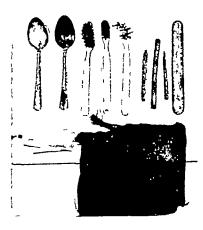


Fig 1 Foreign bodies removed from ileum, appendix, and stomach of patient.

moved which, on inspection, turned out to be two teaspoons one toothbrush, and a tongue stick matted together with wool fibers from a previously ingested piece of blankst material. The bowel was then closed with horizontal sutures and the rest of the abdominal viscera polpated. The appendix was hard and firm and soutely inflamed. It was moved and two nails about the length of the appendix, and a wood splinter probably from another tongue stick, were found within its lumen. Further exploration revealed foreign material in the stomach from which was removed two toothbrushes and a square piece of molesian cloth about 8 inches square. The patient's abdomen was closed without drainage

Postoperative treatment consisted of the usual intertion of a Levin tube attached to a Wanger-stem suction appearatus, together with the use of ponicillin and sodium sulfadaxine as prophylactic measures. The patient made an uneventful recovery with no apparent result on his mental status.

# DEPARTMENT OF WORKMEN'S COMPENSATION

CONDUCTED BY DAVID J KALISKI, M D, DIRECTOR

Viewpoints of Workmen's Compensation Administration as to Occupational Diseases\*

WORKMEN'S compensation legislation has evolved more uncertainly and slowly in occupational diseases than with respect to accidental injuries. Modern chemical and technologic developments necessitate equal advances in industrial medicine and in workmen's compensation legislation.

Medical knowledge is largely in the possession of a small group of medical scientists and not sufficiently spread among general practitioners who see the bulk of workmen's compensation cases. It is necessary to arouse what Miss Donlon calls informed curiosity on the part of the medical profession in respect to industrial diseases, so that these patients may be recognized and thus adequately treated and compensated

The second injury law passed in 1944 extends to all cases of industrial injury and occupational diseases, and is financed through annual pooled carrier contributions spreading the cost over industry as a whole. The new dust disease law, which became effective in 1947, limits the employer's liability to the first five years in cases of total disability and death, the balance of liability being charged against the Second Injury Fund. Workers get full compensation benefits, but a substantial part of liability is transferred from individual employers to the industry as a whole

Now a worker disabled by one of the enumerated diseases may file a claim for benefits and give notice to his employer within 90 days after disablement and after knowledge that the condition was due to his employment, notwithstanding the lapse of more than the usual short statutory periods of limitation with respect to notice, claim filing, etc. Where death is caused by one of these slow developing diseases, benefits may be awarded to dependents where death ensued within five years after contraction of the disease

New York State has a sound and forward looking interest in workmen's compensation measures and in some respects there is no counterpart in other states in respect to occupational diseases. Current views of workmen's compensation administration in pul monary and other occupational diseases in New York State are briefly summarized.

- 1 Benefits to disabled workers should be no less for an occupational disease disablement than for a traumatic disability
- 2 The medical characteristics of certain latent or slow starting diseases call for a realistic period of limitation not measured from last exposure
- 3 The burden of workmen's compensation costs may be a serious deterrent to the employment of workers who, in previous employment, have been injuriously exposed to hazards that cause progressive deterioration, as in the dusty trades Spreading excess workmen's compensation costs to industry as a whole improves employment opportunities.
- 4 Similarly, the middle aged and older workers, and those of all ages who have permanent physical impairments, are more readily employable when excess workmen's compensation costs for second injury or occupational disease are lifted from the employer and transferred to a Second Injury Fund.
- 5 Rehabilitation of workers who would be harmed by return to an occupational exposure calls for payment of workmen's compensation benefits until earnings in a medically safe new employment equal those in the medically unsafe old employment.

Miss Donlon seeks the cooperation of the medical profession at every level, especially in occupational diseases. Expert consultants are available throughout the State to give competent diagnosis, prognosis, and opinions on casual relationship and treatment. There is urgent need for establishment of accepted standards in such matters as laboratory and tray examinations. There is need for more emphasis on industrial medicine in medical education. "A society whose survival is dependent on possession and use of the most modern processes of industrial production requires for survival also sound medical knowledge as to the hazards inherent in those processes."

<sup>\*</sup>An address by Miss Mary Donlon Chairman of the Workmen's Compensation Board of the State of New York at the Sixth Saranac Symposium at Saranac Lake New York, on Friday October 3 1947 Owing to the shortage of space we regret the inability to publish in full Miss Donlon's excellent article. It bears a message of peculiar significance to all physicians authorized to treat workmen's compensation claimants. You are urged to obtain a copy of the full article from Miss Mary Donlon, Chairman of the Workmen's Compensation Board. 80 Centre Street, New York 13 New York.

# MEDICAL NEWS

## Union Plans Health Center

THE International Ladies Garment Workers Union has begun a \$1,000,000 expansion project for its Union Health Center at 275 Seventh Avenue, New York City, it was learned recently from Dr Leo Price, the center's director Half completed at present, construction and installation work is expected to be finished by next summer

At present an estimated 2,000,000 in vanous unions under collective bargaining now have health and benefit programs, with John L Lewis' coal miners most notable among this group. Many of these unions are considering supplying their own medical service, according to the announcment made by Dr Price.

## Nurses Have Civic Responsibility

NTURSES as individuals and as a specialized group must break out of their "professional seclusion," recognize the tie-up of politics and everyday life and "be prepared to take the initiative with respect to all economic, social, and political problems" affecting their interests, Ralph E Becker, chairman of the Young Republican National Federation, told a meeting of nurses recently

Mr Becker spoke at a sectional luncheon of the joint convention of the New York State Nurses Association and the New York State League of Nursing Education at the Hotel Pennsyl-

Discussing the civic responsibility of nurses, he emphasized the need for practical political knowledge "Unless you will take an interest in government and actively participate in some way in its affairs, you will be the loser," he declared. It is the responsibility of the profession to "make the rest of the people aware of what your profession is accomplishing, what its needs are, and what it contributes to society as a whole," he concluded

## Masons to Fight Rheumatic Fever

A MASONIC Fund for Medical Research and Human Welfare has been organized by the Masonic Grand Lodge of the State of New York to support intensive research into the causes and possible cures for rheumatic fever, it was announced recently

Backed by prominent child-care specialists, the order will engage in a fund-raising campaign from January until May Funds will be solicited only from the organization's 270,000 members in the State, but will be available for all, regardless of affiliations or geographical location. The doctors who will be asked to serve on a medical advisory

commission to the fund are Dr Ralph H Boots, assistant clinical professor of medicine at the College of Physicians and Surgeons, Columbia University, Capt Morris Brooks, USNR, assistant district medical officer, Third Naval District, Dr Russell L Cecil, School of Medicine, Cornell University, Dr Arthur C DeGraff of N Y U, chairman of the board of Irvington House, a home for rheumatic children in Irvington, Brig. Gen Guy B Denit, surgeon, First Army Area, Dr Francis Schwentker, pediatrician-in-chief, Johns Hopkins University, and Dr George C Woodford, medical director of the Home Life Insurance Company

## International College of Surgeons Inducts Members

A T THE Twelfth Assembly and Convocation of the United States Chapter, International College of Surgeons, held in Chicago on October 3, the following New York State doctors were among the 810 surgeons inducted into the college Fellows—Drs Louis Kleinfeld, M Russell

Fellows—Drs Louis Kleinfeld, M Russell Nelson, Salo Marek Boltuch, Joseph Laval, Hermann J Lukeman, Robert Gutierrez, Meyer Leo Goldman, Horace E Ayers, Thomas J Kirwin, Lester H Moskowitz, Jerome Wagner, and Abbey David Seley, all of New York City, Sherman W McIlmoyl and William T Shields, Jr., Troy, Kenneth Thomas Bowc, Hornell, Louis H Baretz, Bernard N Gottlieb, John J Black, and Bernard Pines, all of Brooklyn, Dante James Morgana, Lockport, William Vernon Wax, Catskill, Leslie A. Dickinson, Michael Jay Crino, Francis R. Daniels, James S Houck, Lynn Rumbold, and Leo Francis Simpson, all of Rochester, Joseph D Hallinan, Richmond Hill, Isidore Berger, the Bronx, Peter Byron, Corona, Henry Hillel, Syracuse, Austin B Johnson, Far Rockaway, Anoch H

Lewert, Jamaica, Giacento C Morrone, Yonkers, Alexander Cameron, Hempstead, and Christopher J Di Crocco, Staten Island

Associates —Drs John Francis Connor, George E Martin, and Adolph Glaser, all of Troj, I. Harvey Schotter, Irving Kalow, Joseph M Armergol, Harry J Bobb, Max B Nathanson, and Henry I Scheer, all of New York City, James Raymond Kelly, Hornell, David J Weyler, Islip Terrance, William F White, and James G Kanski, Buffalo, Michele Angelo Raffaele Raia, Louis J Baskin, and Anthony F Sava, all of Brooklyn, Roman R. Violyn, Amsterdam, Myron L Hafer, Patchogue, Francis A Mastrianni, Mechanicville, George E. Christman, Far Rockaway, Harold Couriney, Syracuse, Dudley B Fitz-Gerald, Lockport, and Edwin R. Linwood, Rockville Centre

Affiliates—Drs Francis A Mastrianni, Mechanicville, Lester J Schultz, New York City, Lows J Baskin, Brooklyn, Vincent T Laquidara, Troy, and Arthur A. Rothman, Williston Park.

#### MEETINGS-PAST AND FUTURE

Association for the Advancement of Psychotherapy

Dr Emil A. Gutheil, New York City spoke on Training in Psychotherapy" at the monthly meeting held on October 31 at the Academy of Medicine Building, New York City

Rochester Academy of Medicine, Obstetrical and Gynecological Section

Observing the one hundredth anniversary of the discovery of the cause and prevention of puerporal fover by Semmelweiss, the Section held a dinner meeting on October 14 at the Rochester Academy of Medicine. Dr Palmer Findlay of Omaha, Nebraaka, was the guest essayist.

American Association for the Study of Goiter

The annual meeting will be held at the King Edward Hotel Toronto Canada, on May 6, 7 and 8, 1948. Program for the three-day session will consist of papers dealing with golter and other diseases of the thryoid gland, dry clinics, and demonstrations.

National Society for the Prevention of Blindness

Of interest to persons who are directly or indirectly concerned with eye health and safety will be the three-day conference to be held on April 5 6 and 7 1948, at the Hotel Radisson, Minneapolis Minneaota.

Details concerning the program may be obtained by writing to the Society at 1700 Broadway, New York 19 New York.

Eastern New York Eye, Ear Nose, and Throat Association

Meeting in Albany on October 2, the Association participated in a Clinic Day at the Albany Hospital attended a dinner at the Albany Country Club, and conducted a business meeting and selentific session Guest speaker was Dr Lyman Richards, of Boston who gave a talk on the psychosomatic factor in ophthalmology and otolaryngology

At the November 6 meeting, held at the Hendrick Hudson Hotel, Tro, guest speaker was Dr Russel N de Jong, head of the neurological department of the University of Michigan Medical School, Ann Arbor Michigan. Dr do Jong's topic was neurology as related to ophthalmology and otolaryn gology Discussion of his paper was ked by Dr Robert D Whitfield, Albany and Dr Isaac Shapiro Schénectady

Rochester Academy of Medicine

Dr John H. Tulbott, professor of medicine at the University of Buffalo School of Medicine spoke on "The Pathogenesis and Treatment of Gouty Arth ritis at the October meeting of the Academy Participating in the discussion following the presentation were Dr Samuel H. Baasett and Dr Jacob D Goldstein, of the University of Rochester School Medicino, and Dr Charles L. Steinberg, associate attending physician at the Rochester General Hospital.

At the November meeting Dr Harold G Wolff associate professor of medicine at Cornell University Medical College, spoke on 'Headache Mechanisms'

#### PERSONALITIES

Honored.—Colonel Jos. ph Haas who was awarded the Legon of Ment at a cormony in the Seventh legimental Armory New York City for exception ally mentoficus conduct in the performance of out standing services as commanding officer of the 120th Station Hospital from September 16, 1942, to August 21 1945 A graduate of Fordham University Hedical School, Dr Haas entared the service in July 1942, and has also been awarded the Bronze Star Medal Dr Robert J Booher associated with the Pack Medical Group New York City, who addressed the annual meeting of the Gulf Coast Clinical Society in Mobile, Alabama, rocently on Recent Advances in the Treatment of Cancer of

Recent Advances in the Treatment of Cancer of the Gastrointostinal Tract Dr George Schwarts, New York City who lectured on Heart Block' on October 21 at the Parkchester General Hospital, under the sponsorship of the New York Council of Surgeons, and Dr Milton Birnkrant, New York City who lectured on Interesting Cases from the Department of Park.

Department of Radiology on October 28. Appointed.—Dr Ethan Flagg Butler Elmira former consultant on thoracic surgery at the Veterans Administration Hospital at Sampson as chief medical director for the Veterans Administration in Now York State Dr Llonel Dichtor, physician-in-residence at the Arnot-Ogden Hospital, Elmira, as medical officer of the Elmira Naval Reserve Unit Dr Suo Thompson Goull former

Columbia County Health Commussioner and a director of the American School Health Association, to the committee on the selection of those persons entitled to fellowships in the American Public Health Association Dr Frank P Light, to the post of chief of the department of obstetries and gynecology at the Long Island College Hespital, succeeding Dr Alfred C Beck Dr John G Lynn, former chief psychiatrist at Grasslands Hospital, Valhalla, to the post of director of the Bureau of Mental Hygene, Territory of Hawaii.

New Offices.—Dr Michael A. Colella, Rome, for

New Offices.—Dr Michael A. Colella, Rome, for practice of general medicine and neuropsychiatry in Utics. Dr Charles Wilson Collins, former commander in the United States Navy Medical Corps, general practice in Saratoga Springs. Dr Guido A De Blasio recently discharged from the United States Army as a major in the Medical Corps in Mount Vernon for the practice of surgery. Dr Charles L. Dubuar, general practice in Barneveld in association with Dr. Albert C. Redmond Dr. Parker Hoffman, of Painted Post, EENT practice in Corning. Dr Charles Maxwell Hower formering the Corning of Bloomsburg Pennsylvania, practice of surgery and medicine in Elinira. Dr. David H. MaoFarland, practice of urology in Utics, succeeding his faller the late Dr. Howard D. MaoFarland. Dr. Joseph Mellow, former chief of urology at the United States Army Eighth Station Hespital in the Pacific

theater, general practice in Port Washington Dr John D Sponnoble, general practice in Gloversville Dr James H Van Marter, recently discharged

from military service with permanent rank of Lieutenant Colonel, Medical Corps, general practice in Groton

Dr Alexander Wolf, after five years' service

in the United States Army as director of the group psychotherapy program at Fort Knox, Kentucky, neuropsychiatrist at the 108th Evacuation Hospital and chief of professional services in the Ninth Army Combat Exhaustion Center in the European Theater, practice of neuropsychiatry in New York

## COUNTY NEWS

#### Canandargua County

Dr C Harvey Jewett was host to members of the Canandaigua County Medical Society at the October dinner meeting at his home in Canandaigua Dr Jewett presented a paper on "The Rice Diet for Hypertension," and Dr Frederick C McClellan gave a report of the meeting of the American Uro-logical Society recently in Saratoga Dr James F Maltman was host for the November

andaigua Talks were Hurlbutt, Rushville, 7 meeting at the Hotel Canandaigua presented by Dr B C Hurlbutt, Ru and Dr J Wendell Howard, East Bloomfield

## Cattaraugus County

Dr F P Keefe, of Olean, spoke on "Skin Grafting—Indications and Modern Technics" at the meeting of the Cattaraugus County Medical Society, held on October 16 in Glean The speaker was introduced by the president, Dr J S Fleming

Joining with the Society at a dinner preceding the meeting were members of the County Woman's Auxiliary, who held a separate business meeting

#### Cortland County

Postgraduate instruction, arranged by the Council Committee on Public Health and Education of the Medical Society of the State of New York for the Cortland County Medical Society, was held on November 21 at the Cortland County Hospital, Cortland

Dr F J Schoeneck, professor of clinical obstetrics at the Syracuse University, College of Medicine, spoke on "Gynecology in General Practice"

## Kings County

The Pediatric Section of the Kings County Medical Society and the Academy of Medicine of Brooklyn will hold the third in its series of scientific meetings on January 26 The speaker will be Dr. H. W. Dargeon, of Manhattan, whose topic will be "Neo-plastic Diseases in Infancy and Childhood" The meetings are held in the Kings County Medical Society building, 1313 Bedford Avenue, Brooklyn, and begin at 9 PM

Dr Abraham Walzer was elected president of the Brooklyn Dermatological Society at the October meeting of the group, when officers were selected to serve for the coming year

Other officers named are Dr E A. Gauvain, vice-president, Dr I N Holtzman, secretary-treasurer, Dr S H Silvers, editorial secretary, and Dr S I Greenberg, assistant editorial secretary

## Lewis County

The Lewis County Medical Society has reaffirmed its policy against publication of names of members treating medical and surgical cases. Dr L A.

Avallone Lowville, president of the group, declared the action was prompted because "publicity is considered unethical and unprofessional"

## Nassau County

Dr Guy F Robbins, from Memorial Hospital, New York, spoke on "What Can the General Practitioner Do About Lowering Cancer Mortallty" at the meeting of the Nassau County Medical Society on October 28 at the Elks' Club, Hempstead The postgraduate instruction was arranged by the Council Committee on Public Health and Education of the Medical Society of the State of New York for the county group

The annual dinner dance of the Nassau County Medical Society will be held December 6 at the Garden City Hotel

### Queens County

A motion picture and talks on aviation featured the meeting of the Queens County Medical Society on October 28 at the Society's headquarters "The Paratrooper in the Making," a film released by the United States Army Air Forces, was shown, and Dr M Martyn Kafka, former flight surgeon with the LL

the US Army Air Corps, introduced the topic.
Speakers were Dr Frederick Hopkins Shillito, medical director of the Atlantic Division of Pan-American World Airways and a member of the faculty of the College of Physicians and Surgeons, Columbia University, whose topic was "Who Can Fly," and Dr John M Baldwin, medical director of the Inter-national Division of Trang World Airgans and also a national Division of Trans-World Airways and also a member of the faculty of the College of Physicians and Surgeons, whose topic was "Explosive Decompression in Commercial Aircraft"

A dinner preceded the meeting

The last two in a series of four lectures being given by Dr Henry A. Reisman, director of pediatrics at Queens General Hospital, will be held December 3 and December 10, at 4 30 PM Topics for the remaining lectures are "Congenital Intestinal Disturbances in Children" and "Pulmonary Diseases in Children"

The series is sponsored by the Graduate Education Committee of the Queens County Medical

Society

#### Sullivan County

"Meningitis" was the topic of the lecture given by Dr Emanuel Appelbaum, chief of the Meningitis Division, Bureau of Laboratories, City of New York Department of Health, on November 19, at the Monticello Hospital, Monticello, for members of the Sullivan County Medical Society The postgradu-Sullivan County Medical Society The postgraduate instruction was arranged for the County Society Health and by the Council Committee on Public Health and

Education of the Medical Society of the State of New York, in cooperation with the New York State Department of Health.

Schenectady County

Dr William Dock, professor of medicine at the Long Island College of Medicine spoke on Heart Fallure and Its Management at the meeting of the Schenectady County Medical Society on November

4 at the Ellis Hospital, Schenectady
This was part of a sories of postgraduate in
struction arranged by the Council Committee on
Public Health and Education of the Medical Society of the State of New York.

#### INDUSTRY MUST ASSUME RESPONSIBILITY IN MEDICINE

Business and industry must assume an increasing financial responsibility for the nation's medical schools if the United States is to maintain its leader ship in health control, Chancellor Harry Woodburn Chase, New York University told leading business mon recently

"Faced with the problem of increasing student bodies, without a corresponding increase in income the average medical school in this country cannot hope to maintain its standard of instruction unless business and industry assume their responsibility," Chancellor Chase said — Its only alternative is to Its only alternative is to seek assistance through tax funds, which might lead eventually to government control of health and medicine

Chancellor Chase quoted figures showing that of the total of \$43,000 000 that will be needed to operate the medical schools of this country in 1948, student fees will provide no more than \$12,000,000 and probably less. The remaining \$31 000 000 will be obtained from income from endowments, general university funds, appropriations from tax funds gifts, and similar sources.

Chancellor Chase a challenge came at a meeting of more than 50 leaders in the New York City business section, called by George W Davison, chairman of the board, Central Hanover Bank and Trust Company, in connection with the appeal for \$4,000,000 in glits from business firms for the New York Uni

versity Bellevue Medical Center Dr Howard A. Rusk and Dr Anthony J Lanza, directors, respectively of the Center's Institute of Rehabilitation and Institute of Industrial Medicine also emphasized the importance of future planning by business to assure the health of industrial workers.—The Medical Advance October 1947

#### NATIONAL STUDY OF CONGENITAL MALFORMATIONS AND MATERNAL INFECTION

In an effort to collect more precise data on the relationships between certain maternal infections and congenital malformations a nation-wide study is being sponsored by the American Academy of Pediatrics and the National Society for the Prevention of Blindness.

Questionnaires are being sent to obstetremans, ophthalmologists, and pediatricians, seeking the reporting of cases of German mesales in expectant mothers and of children with congenital defects that might be attributed to other injections in the expectant mother such as measles, chicken pox, mumps, and influenza.

Although an association has been established between the occurrence of German measles early in prognancy and certain congenital defects in the off spring information is lacking as to the frequency with which this happens and as to the possible influ ence of other communicable diseases that might have been contracted by the expectant mother

Data will be studied by the following committee Dr Herbert O Miller, professor of pediatnes, University of Kansas Hospitals, Kansas City, Kansas, Drs. Stewart Clifford and Clement A. Smith, both of Boston Massachurotts Dr Josef Warkany of Cincinnati, Ohio, Dr James Wilson, of Ann Arbor Michigan, and Dr Horman Vannet of Southbury. Connecticut. Physicans knowing of cases are urged to registor them with Dr Miller, chairman of the committee.

# HOSPITAL NEWS

## The Hospital Bed Shortage—Real and Apparent

THE Bulletin of the Hospital Council of Greater New York noted recently the changing demands for various types of hospital accommodations and suggested plans for benefiting the community and the hospitals The hospital bed shortage, according to the Council, is now in a state of change for reasons

other than the incidence of disease

"For this year, and since last year," said the Council, "the demands for ward services have been increasing steadily, while there is less evidence of acute shortage in private and semiprivate accom-Meanwhile the municipal hospitals eing taxed to capacity The improved modations are again being taxed to capacity financial position of civilians during the war years and the emphasis on personal health as a war asset contributed to the sharply increased demand for private and semiprivate accommodations, so that a large number of ward beds then remained empty "

In addition to the recommendation on over-all planning, the Council suggested the following five studies as means by which the community and the hospitals may reduce the number of new general care beds which may be needed flexibility of accommodations, admission practices, size of hospitals. types of facilities required, and types of service re-

Flexibility of accommodations was described as a means of adjusting to meet varying demands for different types of accommodations. It was noted that in 1939 general hospital ward occupancy was 91 per cent, that by 1944 it had dropped to 72 per cent, and that now the trend is upward again Hospital Council, in urging standardization of facilities as the best assurance for complete flexibility, said, "The physical facilities for ward and semiprivate facilities may be identical. The idea is gaining acceptance that it is desirable to reduce the size of wards to a maximum of four beds "

In discussing the size of hospitals as an important factor in reducing the bed deficit, the Hospital Council said that the Commission on Hospital Care of the American Hospital Association had completed studies indicating that it is not possible to attain an average annual occupancy of 80 per cent in hospitals of less than 200 beds "It may be stated that the hospital needs of a community are met more effectively by five hospitals of 200 beds each than by ten hospitals of 100 beds each Wherever the density of population and the transportation of facilities permit, integration of hospital facilities should provide for hospitals of at least 200 beds each

The Council's recommendation that specialty hospitals, most of which are of less than 200 beds, be integrated into general hospitals is not based on size alone, it was explained, but is primarily dictated by the advances in medical care and the need for

interrelationship between general care and the specialties

The Council suggested a study of admission practices because, "the community quite frequently dictates practices which may increase the need for additional hospital facilities Many hospitals are now called upon to provide a bed at any time the doctor or the patient desires, irrespective of the urgency of the case Hospitals offering such serv ices are compelled to keep a surplus of beds avail able at all times, and this practice only adds to the bed deficit by reducing the number of beds to other Perhaps hospitals should offer some monetary inducement for admissions on a hospitaldeveloped schedule which will help to maintain an even flow of patients"

Recommending that hospitals examine the types of facilities required in their plans to reduce the bed deficit, the Hospital Council said that many patients using general care services should utilize other types of services if adequate facilities were available. Special references were made to convalescent care and patients with long-term illnesses The Bulletin said that Dr Edward M Bernecker, Commissioner of Hospitals, directed a study by the Department of Hospitals for the Hospital Council in April, 1946, which "showed that 22 5 per cent of the general care beds in municipal hospitals were used by patients with long-term illnesses Previous studies had indicated that about 20 per cent of the general care beds in voluntary hospitals were occupied by pa

tients with long-term illnesses" In suggesting that hospitals also consider the types of service required, the Hospital Council said, "The cost of hospital care has increased to such an extent that it is necessary to consider the need for inpatient service as well as the type of hospital facilities which might be required Many of the admissions are for diagnostic evaluation Although ancillary services provided by hospitals are necessary, much of the work could be done without admission to the inpatient service if adequate facilities for the care of ambulant patients were available The Hospital Council endorses this type of facility as a means of improving the medical services available

to the community "More recently evident are the results of studies which have found that many patients using hospital facilities may be cared for at home, and at greatly reduced cost without sacrificing the quality or number of medical services. In particular, patients with long-term illnesses often show marked improvement in health and spirit away from the hospital and in their homes where they have medical supervision and necessary medical, nursing, and housekeeping

services"

# Memorial Hospital Issues Report on Cancer Attack Plans

MEMORIAL Hospital, in New York City, is "attempting to establish something never before done—a cancer university for the advanced study of cancer in man," it was shown in the quadrennial report of the hospital by its president, Reginald G Coombe

Entitled "The Use of Your Money for Cancer."

the report covers the four most momentous years in the history of the hospital. During this period the nation's oldest hospital devoted exclusively to the treatment of cancer and allied diseases has expanded from a single building to the world's largest cancer When completed next year the center will center cover an entire block.

[Continued on page 2614]



facts have been established

- 1 The administration of synthetic Folic Acid to persons with Addisonian pernicious anemia nutritional macrocytic anemia and aprue in relapse is followed by enormous blood regeneration. Strength and vigor return often followed by a rapid gain in weight. There is an increase in red blood cells and hemoglobin
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[Continued from page 2612]

Stressing the importance of a university for the study of cancer, Dr C P Rhoads, director of Memorial, said that in the space of five years the hospital has arrived in the area of a major educational and scientific institution devoted to all aspects of neo-plastic disease From a simple hospital "it has achieved the function of a graduate school of cancer medicine." Dr Rhoads declared that cancer as a disease receives only transient attention in medical schools. This, he said, requires acceptance by the cancer hospital of its duty to maintain the university standards of intellectual activity

Seventy-eight fellows in surgery, medicine and

research, pathology and radiology are studying at Memorial Center this year, the report says. Doc tors have come to Memorial from all over the United States and twenty-one foreign countries. They have returned to head cancer clinics and hospitals throughout the world, according to the report of Dr

Allen O Whipple, clinical director

The report showed that Memorial served the needs of 113,000 outpatients in 1946, 12,000 more than in the previous year The Strang Prevention Clinic, one of its units, examined 14,000 presumably well persons for first signs of cancer, as compared with

150 in 1940

## Division of Physical Medicine at Rochester Hospital

ESTABLISHMENT at Rochester General Hospital of a division of physical medicine—the first to be incorporated into the services of a Rochester area hospital-was announced in October by Dr Frank C Sutton, director

Head of the new division, whose functions will embrace the practice of one of the most rapidly expanding fields of medicine, is Dr Alfred L Lane, a Cornell Medical School graduate who served with the medical services of the Army Air Forces from

Dr Lane recently completed studies in physical medicine at Bellevue Hospital, New York City, under a fellowship set up under the \$1,100,000 grant made by Bernard M Baruch in 1944 for the adequate development of physical medicine in this country

In one of its major functions as part of a hospital's community service, Dr Lane explained, physical medicine "takes over where surgery and ordinary medical care leaves off" It seeks, he added, to rehabilitate the temporarily disabled—to get the fracture case back on his feet and back to his job more quickly—and to train and condition the per manently disabled to make the maximum use of limited faculties

While the new division, staffed at present by Dr Lane and two therapists, will for the time being operate only for the service of General Hospital patients, Dr Sutton said he can envision future development that will allow for widely encompassing service that will make the division an important source of economic and social benefit to the Roches-

ter community

## State to Operate Onondaga Sanatorium

OVERNOR Thomas E Dewey has announced that the State will take over operation of the 205-

bed, twenty-acre Onondaga County Tuberculosis Sanatorium, effective April 1 This is the first county institution of its kind to be acquired by the State, under provisions of a law enacted in 1946, in a program for eradication of tuberculosis in the State within the next twenty

Onondaga County has operated the sanatorium since 1910, and its acquisition by the State will save the county about \$400,000 a year Governor Dewey said its operation by the State would be integrated in a State-wide master plan for the free care of tuberculosis patients He said it was hoped that the institution would be operated in close cooperation with Syracuse University and its medical school, providing medical teaching and special research facilities

Negotiations are being carried on for the acquistion of several other county tuberculosis hospitals

by the State to serve regional areas

## **NEWS NOTES**

A million-dollar expansion of Veterans Administration mental hygiene clinics in Manhattan, Brooklyn, and the Bronx permitted discontinuance of private psychiatric care for vets in those boroughs effective October 31 Joseph F O'Hearn, acting deputy State administrator of V.A., said the expanded program will provide psychiatric care for vets at half the present annual cost of \$2,000,000

The Rockefeller Foundation and the New York Foundation have awarded \$39,000 to Columbia University for further study on the use of glutamic acid, it was announced. It was stipulated by the foundations that the grants be used for work in brain chemistry carried on by Dr Heinrich Waelsch at the N Y State Psychiatric Institute and Hospital

Genesee Memorial Hospital in Batavia is waiting until "building materials are available and priced within reason" before starting construction of its new 100-bed hospital, according to a report from its board of directory. board of directors

On September 8, the Roslyn Park Hospital marked the first anniversary of opening its doors to the general public and celebrated a year of successful operation

The first clinic for the prevention and detection of cancer to be operated by the New York City Department of Health was opened in October The project has been undertaken on a cooperative basis by the City Health Department, the New York City Car-

[Continued on page 2818]

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For special announcements, please see pages 2542 and 2582

#### PROGRAM FOR GENERAL PRACTITIONERS AT A.M.A. CLEVELAND SESSION

In addition to technical and scientific exhibits, a program designed particularly as postgraduate edu cation for general practitioners will be presented at the supplemental session of the American Medical Association in Claveland, Ohio January 5-9 1948

The Council on Scientific Assembly, whose chair man is Dr. Heary R. Viets of Boston, has prepared a program which will include papers, panel discussions, and symposia on many of the topics now most promi nently before members of the medical profession. Among the topics to be covered are peptic ulcar blood dyscrassas (any abnormal composition of the blood), the chronic invalid posthospital care of patients with cancer treatment of the fat and the lean cancer of the prostate the use of BCG vaceme in the prevention of tuberculosis utorms bemorrhage multiple injuries in automobile acci-dents the treatment of pathologic conditions in adolescence the treatment of the healthy and sick diabetic patient, jaundice the Rh factor and the interpretation of x ray films of the cheet.

During the first two days of the session the Council on Industrial Health of the American Medical Association will conduct a program devoted particularly to problems in its field.

Planned for the scientific exhibit is a demonstration of the operation of a diagnostic cancer cline in which viating physicians will be given the opportunity to undergo themselves the routine of such an examination .- A.M.A News October 10 1947

[Continued from page 2614] cer Committee, Cornell University Medical College, and the Strang Cancer Prevention Clinic of Memo-

It is under the direction of Dr Emerrial Hospital son Day, assistant professor of Public Health and Preventive Medicine at Cornell Medical College

Grasslands Hospital, Valhalla, is the most recent participant in the new Regional Plan of New York University College of Medicine to make its facilities available to suburban and rural hospitals

The Grasslands Hospital, which is maintained by Westchester County, will send a contingent of five doctors to the sessions created under the plan will be the largest delegation from any of the participating members, which include New Rochelle Hospital, also of Westchester County, Flushing Hospital and Dispensary, Flushing, Long Island, Monmouth Memorial Hospital of Long Branch, and Pitkin Memorial Hospital of Neptune, both of New Jersey, North Country Community Hospital, Glen Cove, Long Island, and St Luke Hospital, Newburgh

Construction work on an integrated system of

hospitals for Canton, Gouverneur, and Alexandra Bay are scheduled to start early next spring, according to an announcement by Edward J Noble.

The A Barton Hepburn Hospital in Ogdensburg established its own laboratory in October, neces-stating the moving of the St Lawrence County laboratory from the hospital to the Messina town hall. Dr Louis Loeffler is pathologist in charge of the new Hepburn Hospital laboratory

Potsdam General Hospital has enlarged its bed capacity from 59 to 101 during the past year without enlarging its buildings, according to a recent report of Superintendent Paul Sobering

Increased activity in every department was reflected in the annual report of the Frederick Ferns Thompson Hospital in Canandaigua The average daily number of patients was 89 8, the report said which put the capacity of the hospital to a critical test

### PERSONALITIES

Appointed -Dr Bernard Selinger, pediatrician, and Dr Richard Batt, radiologist, to the assistant attending staff at Glens Falls Hospital Louis Loeffler, formerly pathologist at the Decatur and Macon County Hospital, Decatur, Illinois, and the Methodist Hospital, Peoria, Illinois, as pathologist in charge of the A Barton Hepburn Hospital laboratory, Ögdensburg To the board of mana-gers of St Luke's Hospital, Newburgh, Drs James C Donovan, Earl C Waterbury, Carlos Fallon, John

W McKeever, and Charles W McWilliams Dr Thomas C Goodwin, Baltimore, as pediatrician-in-chief of Mary Imogene Bassett Hospital, Cooperstown, replacing Dr Marjorie F Murray, recently named professor of pediatrics at Albany Medical College To the medical staff of Frederick Ferris Thompson Hospital, Canandaigua, Dr Carl B Smith, Victor, and to the courtesy staff, Dr Henry Buxbaum, Canandaigua, Dr Fred Dikler, Manchester, and Dr W H Kober, Lima.

#### NECROLOGY

[Continued from page 2607] Radiological Society of America, of which he was at one time a first vice-president, a member of the medical societies of Kings County and New York State, and the American Medical Association

Paul Edward Wesenberg, MD, of Brooklyn, died on August 8 at the age of 66 Dr Wesenberg, a Dr Wesenberg, a

fellow of the American College of Surgeons, and a member of the Medical Society of the State of New York and Kings County Medical Society, and the was associate American Medical Association, was associate gynecologist and obstetrician at the Caledonian He was graduated from Hospital Brooklyn Vanderbilt Medical College in 1908

## ONE UP

A girl intern was carefully performing a neurological examination on a male patient He was walking up and down the ward in a manner highly suggestive to her of "scissors gait" Just then a nurse leaned down and whispered, "He'd walk better if he weren't afraid the thermometer would fall

-Medical Fconomics, September, 1947

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## **BOOKS**

Books for review should be sent to the Book Review Department at 1313 Bedford Avenue Brooklyn N Y Acknowledgement of receipt will be made in these columns and deemed sufficient notification. Belection for review shall be based on merit and interest to our readers.

### RECEIVED

Microbial Antagonisms and Antibiotic Substances By Selman A Waksman Revised edition Octavo of 415 pages, illustrated New York, Commonwealth Fund, 1947 Cloth, \$4 00

Pediatric Gynecology By Goodrich C Schauffler, M D Second edition. Octavo of 380 pages, illustrated Chicago, Year Book Publishers, 1947

Cloth, \$6 00

Pye's Surgical Handicraft. A Manual of Surgical Manipulations, Minor Surgery, and Other Matters. Connected with the Work of Surgical Dressers, House Surgeons, and Practitioners Edited by Hamilton Bailey, F.R.C.S. Fifteenth edition. Octavo of 668 pages, illustrated. Baltimore, William & Wilkins Co., 1947. Cloth, \$7.00

An Approach to Social Medicine By John D Kershaw, M D Octavo of 329 pages Baltimore, Williams & Wilkins Co, 1946 Cloth, \$4 50

Treatment of the Patient Past Fifty By Ernst P Boas, M D Third edition Octavo of 479 pages, illustrated Chicago, Year Book Publishers, 1947 Cloth, \$5.75

Diseases of the Nervous System Described for Practitioners and Students By F M R. Walshe, M D Fifth edition Octavo of 351 pages, illustrated Baltimore, Williams & Wilkins Co , 1947 Cloth, \$4 50

A Handbook on Diseases of Children Including Dietetics and the Common Fevers By Bruce Williamson, M D Fifth edition. Duodecimo of 408 pages, illustrated Baltimore, Williams & Wilkins Co, 1947 Cloth, \$4 50

Histopathology of the Ear, Nose and Throat. By Andrew A. Eggston, M D, and Dorothy Wolff, Ph D Quarto of 1,080 pages, illustrated Baltimore, Williams & Wilkins Co, 1947 Cloth, \$18

Psychodrama. First Volume By J L Moreno, M D Octavo of 429 pages, illustrated New York, Beacon House, 1946 Cloth, \$6 00

Dermatologic Clues to Internal Disease By Howard T Behrman, M D Octavo of 165 pages, illustrated New York, Grune & Stratton, 1947 Cloth, \$500

Roentgen Interpretation By George W Holmes, M D, and Laurence L Robbins, M D Seventh edition Octavo of 398 pages, illustrated Philadelphia, Lea & Febiger, 1947 Fabrikoid, \$700

A Manual of Otology, Rhinology and Laryngology By Howard Charles Ballenger, M.D. Third edition Philadelphia, Lea & Febiger, 1947 Cloth, \$4 50

Paravertebral Block in Diagnosis, Prognosis, and Therapy Minor Sympathetic Surgery By Felix Mandl, M D Translated by Gertrude Kallner, M D Octavo of 330 pages, illustrated New York, Grune & Stratton, 1947 Cloth, \$6 50

The Diagnosis and Treatment of Diarrheal Diseases By William Z Fradkin, M D New York, Grune & Stratton, 1947 Cloth, \$6 00

Occupational Diseases of the Skin. By Louis Schwartz, M D , Louis Tulipan, M D , and Samuel M Peck, M D Second edition Octavo of 964 pages, illustrated Philadelphia, Lea & Febiger, 1947 Cloth, \$12 50

The 1946 Year Book of Endocrinology, Metabolism and Nutrition Endocrinology edited by Willard O Thompson, M D, Metabolism and Nutrition edited by Tom D Spies, M D Duodecimo of 573 pages, illustrated Chicago, Yearbook Publishers, 1947 Cloth, \$3.75

Methods of Diagnosis By Logan Clendening, M D, and Edward H Hashinger, M D Octavo of 868 pages, illustrated St Louis, C V Mosby Co, 1947 \$12 50

Atlas of Cardiovascular Diseases Correlation of Clinical Electrocardiography and Cardiac Roent-genology with Clinical History and Autopsy Findings. By Irving J Treiger, M D Quarto of 180 pages, illustrated St Louis, C V Mosby Co, 1947 \$10

May's Manual of the Diseases of the Eye For Students and General Practitioners Revised and Edited by Charles A Perera, M D Nineteenth edition Duodecimo of 521 pages, illustrated Baltimore, Williams & Wilkins Co, 1947 Cloth, \$400

The Years after Fifty By Wingate M Johnson, M D Large Duodecimo of 153 pages New York, Whittlesey House, 1947 \$2 00

Medical Addenda. Related Essays on Medicine and the Changing Order By The New York Academy of Medicine Committee on Medicine and the Changing Order Octavo of 156 pages New York, Commonwealth Fund, 1947 Cloth, \$175

Synopsis of Allergy By Harry L Alexander, M D Second edition. Duodecimo of 255 pages, illustrated St Louis, C V Mosby Co, 1947 Cloth, \$3 50

Infant Nutrition A Textbook of Infant Feeding for Students and Practitioners of Medicine By P C Jeans, M D, and Williams McKim Marriott M D Fourth edition Octavo of 516 pages, illustrated St Louis, C V Mosby Co, 1947 Cloth, \$350

Arthritis and Related Conditions. Edited by Theodore Franklin Bach, M D Octavo of 472 pages, illustrated Philadelphia, F A Davis Co. 1947 Cloth, \$6 50

Preoperative and Postoperative Care By William J Tourish, M D., and Frederick B Wagner, Jr, M D Octavo of 338 pages, illustrated Philadelphia, F A. Davis Co, 1947 Cloth, \$6 00

Physikalische Medizin in Diagnostik und Therapie By Wolfgang Holzer, M D Fifth and Sixth editions Octavo of 769 pages, illustrated Vienna, Verlag Wilhelm Maudrich (New York, Grune & Stratton), 1947 Cloth, \$900 (Bucherei der Physikalischen Medizin, Band II)



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Size of Articles —It is earnestly desired that scientific articles shall not exceed 6 JOURNAL pages at the outside Longer articles tend to lower reader interest. An average of five or six seems to be the most desirable from this point of view Calculation can readily be made by multiplying the number of double-spaced typewritten manuscript pages by the fraction two-fifths, e.g., twelve manuscript pages will make five Journal pages

Manuscripts —Papers must be typewritten on one side only of white sheets consecutively numbered, and be double spaced with one-inch margins. They should be prepared with great care so as to be typographically correct. All headings, titles, subtitles, and subheadings should be typed flush with the left-hand margin. This is imperative for rapid and accurate composition by the printers

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Subheadings —Subheadings should be inserted by the author at appropriate intervals

References—It is the unfailing practice of the New York State Journal of Medicine to use specific "references" rather than "bibliography" There should appear in the text reference numbers, typed above and to the right of the word to which there is a reference. A list, consecutively numbered, of these references should follow at the end of the manuscript (Note that spelling in list is same as in text). The arrangement should be as follows and should include all items.

Books—author's surname followed by initials, title of book, edition, location and name of publisher, year of publication, volume, and page number Thus, Osler, W Modern Medicine, 3rd ed, Philadelphia, Lea & Febiger, 1927, vol 5, p 57

b Periodicals—author's surname followed by

month (day if necessary), year of publishing Thus, Leahy, Leon J New York State 1 Med 40 347 (March 1) 1940

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Case Reports —Instead of abstracts of hospit histories, authors should write these reports in a narrative style with properly completed sentence. All unimportant details should be deleted with residual general negative statements as fit the case.

Tables —While tables are very useful on linear slides in the reading of papers, they fail of this papers to a large extent in the printed page. For the reason it is urged that they be reduced as much a possible to descriptive language

Illustrations—These should be kept to the mixmum necessary to make clear the points to be registered by the author. In some instances the are imperative to proper understanding, in other they are merely picturesque. The latter can be excluded to good effect, both as to space and them inconsiderable cost.

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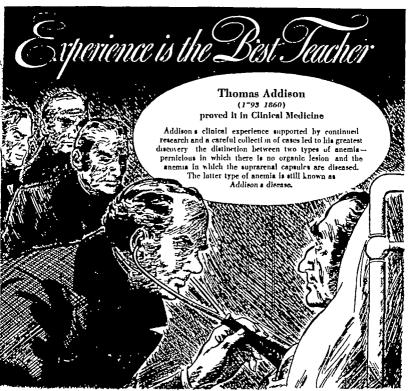
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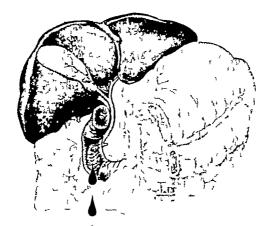
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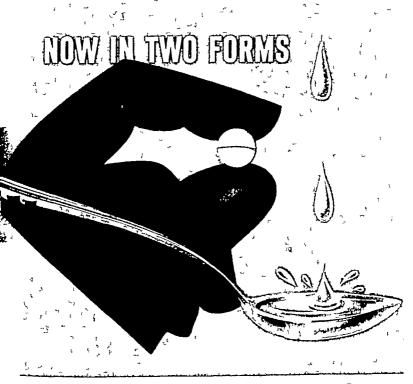


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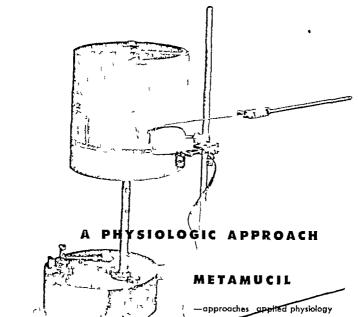
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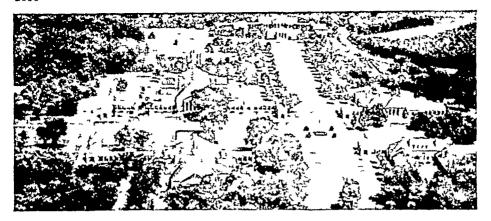
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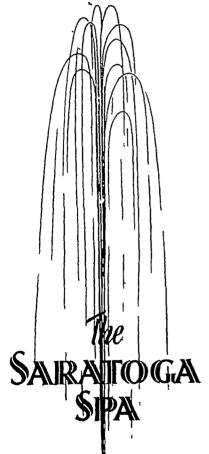
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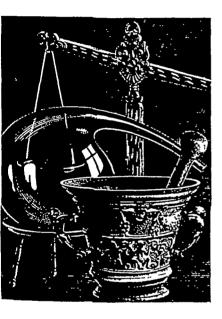
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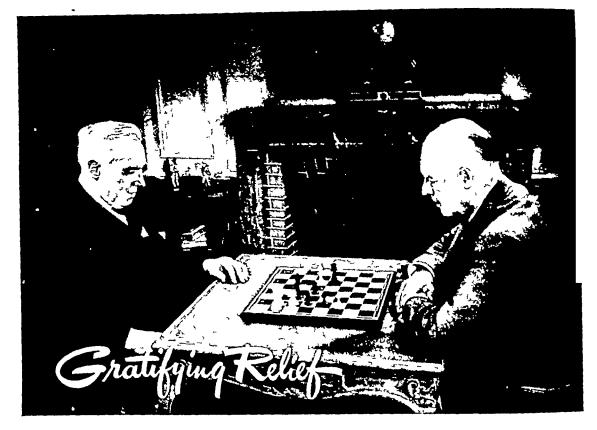
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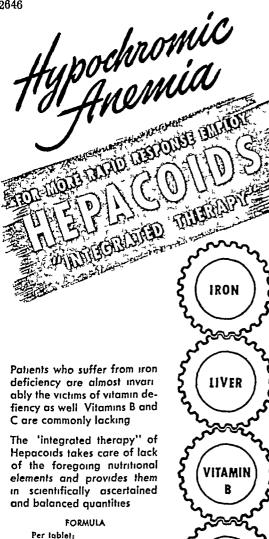
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For easy administration and adequately sustained blood levels, the \_formula must be neither too viscous nor too fluid the penicillin crystals of correct size shape and density the container appropriate to the use intended The following should also be recognized

- 1 I or administration from multiple dose vials, the mixture should be sufficiently fluid to permit easy withdrawal accurate measurement and easy injection
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- 3 When injected from individual-dose cartridges the penicillin in oil and wax suspension should be of slightly thicker consistency. If it is not and the penicillin settles out it cannot be resuspended by shaking, because (a) the volume is too small and (b) the cartridge has no air space
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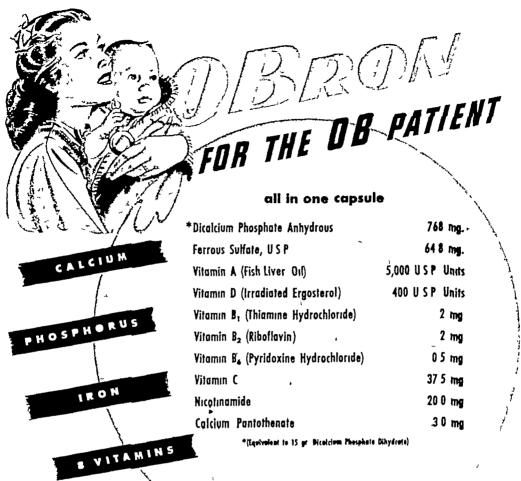
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## intensive sulfonamide therapy

By combining sulfadiazine and sulfathiazole in a single preparation, the dangers of crystalluria and its troublesome complications are greatly reduced Recent studies\* have shown that the total urine solubility of two sulfonamides is greater than that of a single sulfonamide, since the presence of one exerts little influence upon the solubility of the other Consequently, a greater total quantity of concurrently administered sulfadiazine and sulfathiazole can be dissolved in the urine than of either drug alone

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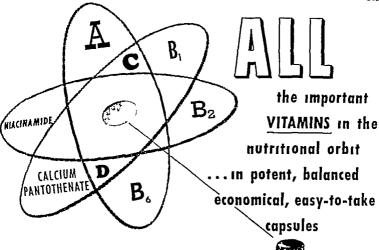
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\*Lehr D Proc.Soc.Exper Biol & Med 58 11 (Jan ) 1945



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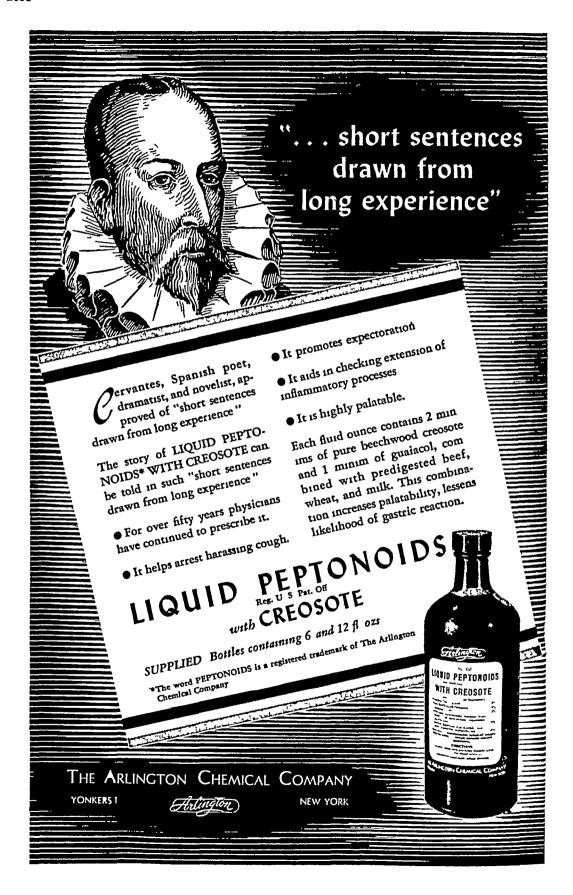


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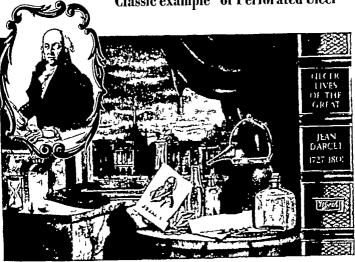


A powdered modified milk product especially prepared for infant feeding, made from tuberculin tested cow s milk (casein modified) from which part of the butter fat has been removed and to which has been added lactose cocoanut oil cocoa butter cornoil and olive oil Each quart of normal dilution Similac contains approximately 400 USP units of Vitamin D and 2500 USP units of Vitamin A as a result of the addition of fish liver oil concentrate



Similar to breast milk

"Classic example" of Perforated Ulcer



JEAN D ARCET, chemist and physicist of 18th century France is cited as one of the first recognized cases of perforated peptic ulcer (in Cruveilhier s Pathological Anatomy of the Human Body)

D Arcet's symptoms appeared only at the age of 72—diarrhea, often with epi gastric or colicky pain. He died suddenly about six months after suffering had be come acute. Autopsy revealed two ulcers

PROSPHALIEL is ideal for drip therapy in bleeding or refractory cases only it is excellent featured as a monarginal as well as a monarginated before. Prosphaljel effectively reduces the acidity of at least five times its own volume of gastric locks and il insertives peptis even in a highly acid medium. Phosphaljel lays a protective costing over the inflamed mecons permitting continuous heading without traiter corresion.

on the lesser curvature of the stomach one with indurated edges and three per forations, the largest of which was 6.7 mm in diameter

If D'Arcet could have had the benefits of today s medical knowledge, with mod ern antacid therapy he might instead be the classic example of a severe case restored to health by intragastric drip treatment.

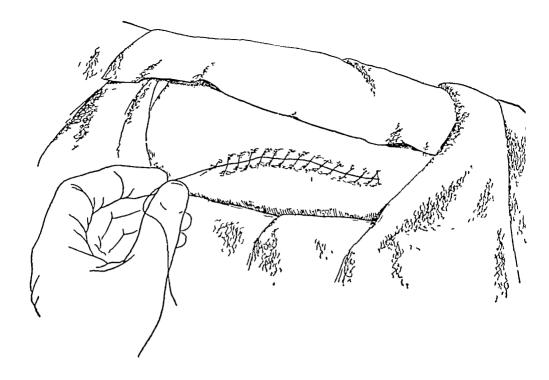


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# Postsurgical healing can be enhanced

In cases with an avitaminosis, wound healing can be accelerated and hospitalization time shortened by preoperative and postoperative administration of Pulvules Becotin with Vitamin C (Vitamin B Complex with Vitamin C, Lilly) Following major surgery there is usually rapid depletion of the water-soluble vitamins. This is particularly true of patients undergoing surgery of the gastro-intestinal tract

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As soon after surgery as the patient can take oral medication, one or more Pulvules Becotin with Vitamin C may be prescribed until the patient resumes normal activity

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One pulvule provides a therapeutic dose of all the known water soluble vitamins





## NEW YORK STATE JOURNAL OF MEDICINE

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VOLUME 47 DECEMBER 15, 1947

NUMBER 24

## Editorials

### Plain Talk, II Costs of Professional Services

In our previous editorial, we pointed out the necessity to separate, in discussing total medical service, the costs of professional from those of ancillary services. Rising costs of living necessarily will increase the cost to the public of total medical service. Organized medicine will be blamed for failure to halt these rising costs of total medical service, it will be pointed out that private enterprise in medicine therefore, is incompetent, irrelevant, immaterial, and helpless Ergo, do away with private enterprise and substitute state medicine, eventually nationalize the whole works.

Now, if the costs of professional services are examined separately they will be found to be relatively stable. The professional fee for an office visit in any community is nearly the same as it was, for example, five years ago "The surgeon's fee for an uncomplicated appendectomy is, in a given community, about what it was five years ago Many more people are enjoying the benefits of voluntary prepayment plans for medical and surgical care which indemnify them against at least part of the professional cost of sudden and sometimes catastrophic illness.

Fee schedules, supposedly minimum in nearly all instances but actually maximum, control the cost for professional services rather rigidly in workmen's compensation practice, federal old age assistance, state and county welfare ambulatory care, Veterans Administration service-connected hometown medical service, many industrial employees' mutual aid associations, and the like

These regulatory mechanisms operate to control a vast volume of medical and surgreal fees. Behind the schedules stands a huge and diverse insurance structure, built up gradually through the years and based on experience tables. To some extent the fee schedules in the aggregate exert an influence on the fee levels charged in private medical and surgical enterprise, tending to provide a not necessarily rigid but a steadying influence on any tendency to permit too wide fluctuations. Some abuses naturally exist, in the main, professional fees do not vary greatly over long penods of time, nor do they seem to be excessive for the quality of service rendered

The cost of the other component of total

medical service, the ancillary services, is quite a different matter. Into this component enter the factors of wages, manufacturing and transportation costs, costs of materials, fabrication, technical assistance, taxes, food, power, and the like. Here may be found the principal reasons for increased costs of total medical services. When the public rightly complains of the greater builden of costs, let it be shown clearly that these arise principally from nonprofessional sources—the ancillary services.

It is true that in the course of time the costs of professional education have increased because of the longer required courses of training. With the establishment of more

and more boards in the specialties and the constant elevation of professional standards of education and postgraduate training, nothing else could be anticipated High quality is expensive in medical professional training, as in anything else

The insistence on higher standards has come from within organized medicine itself. Eventually the longer training will probably force a higher rate of professional fees, but this has not yet occurred to any notice able extent.

At the present time careful analysis of the costs of the ancillary services will reveal the source of most of the increased cost to the public of total medical services

## Compulsion Repudiated

What, if any, is the significance to American Medicine of Mr Truman's declaration at his recent press conference of his faith in free enterprise? Of his rejection of controls as implements of the "police state?"

He was pressed to be concrete by questions which went on the assumption that voluntary food saving will not be enough. Asked whether rationing of food would be adopted in the present drive, he answered no, not unless it becomes imperative. Asked whether he regards rationing as an act of the police state, he answered firmly, yes, anything that is compulsory is the police state in operation.

In previous messages to Congress the President, we seem to recollect, has called for a National Health Program. His administration has sought to bring this into action by means of legislation. That legislation has been the Wagner-Murray-Dingell compulsory "health" insurance.

We are unschooled in political deviousness, but how does one reject compulsion as "the police state in operation" with the one hand and support it with the other? Admittedly, the President was speaking of the food situation at his recent press conference, admittedly, he was not speaking to Congress, admittedly, he was not discussing "health" insurance. He was, or seemed to

be, rejecting compulsion as a method of the police state

This action should have great significance for those responsible leaders in American Medicine who have consistently held to the necessity for free enterprise in this field, those leaders who have resisted compulsion as repugnant to the philosophy of a free nation. If, as seems possible, Mr Truman is shedding the tattered remains of the mantle of Elijah, there should be no call for compulsory health insurance in the forth-coming message to the new Congress in 1948. That is, if the President really means what he appears to have said

Assuming that this is so, the obligation of the medical profession to extend and improve its voluntary medical expense indemnity plans becomes greatly increased Relieved of the necessity to divert a considerable portion of its energies and funds to resisting moves toward compulsor "health" insurance legislation, the profession should be able to turn those energies and funds to good account in developing greater efficiency in the delivery of more good medical service to more people at moderate cost

The way seems to be opened for a greater degree of cooperation between organized medicine, government, and business in the public service, by an apparent repudiation

INY Herald Tribune, Oct. 16 1947

of the principle of compulsion, keystone of the "police state"

Every thinking person would like to see a realistic national health program made an accomplished fact. If Mr. Truman and his administration are serious in repudiating the philosophy and methods of the "police state," no serious obstacle seems to stand in the way. The President's message to the next Congress will be awaited with interest as will the legislation designed to implement it.

### Home, Home in the Housing Project

The word HOME used to mean a great deal Until in the large cities, at least, it was debased by the real estate business A man used to own three, possibly four things-his wife, his children, and his home And possibly his self-respect home might have descended to him he came home, tired from the day's work, and mowed his lawn, spaded his garden, watered his flowers much as he might have groaned over the extra tasks, he was contributing to the flowering of his ego French have a phrase for it "Qui fleurit sa maison, fleurit son coeur" "He who makes his house (to) flower makes his heart flower " His own house, his own grounds! They were a little different from anyone else's They were, in a sense, the expression of his individuality And a man needs that sort of thing When, in middle life, his sentimental fancies may start to stray, his home will anchor him when, perhaps, his wife won't He gets fond of it, and if he gets fond enough of it, he will fight for it Not because the newspapers have blown him up to war fever as a child would blow up bubble gum, but because it is something real, something tangible, something that, next to his wife and children, means more to him than anything in the world

Stuy eant Town and Peter Cooper Village are housing projects, two of the greatest testimonials to private enterprise in New York City, consisting of groups of mammoth apartment houses in process of crection between 14th and 23rd Streets east of First Avenue We yield to no one in our admiration of the erectors of these projects, for the successful efforts they have set forth to provide modern housing We have no better alternative to suggest as long as man will continue to live supine under the wretched conditions that present-day "civilization" provides for him. They

are not yet completed, but they have risen recently with incredible speed, and are expected to provide housing for 25,000 people of the lower income group, those unfortunates (I) who labor under the "white collar" stigma. The white collar used to be a mark of distinction. Now it is a yoke. The white collar man is the one for whom nobody cares. He is the bank clerk, the doctor, for instance. He has no unions. The professional man has no Social Security. He has no comfort of class consciousness. He is the owner of nothing but vast personal responsibilities, anxieties, gastric ul cers, and hypertension.

Suppose he is fortunate enough to get an apartment in Stuyvesant Town. It will be in a well-built building. His roof won't leak. His plumbing will be the best. He will have a reasonable amount of fresh air and sunshine. There will be space between the "units' for green grass and playgrounds for his children. We take our hat off to the

various creators of the housing developments But—suppose a son of one of its proud white collar occupants is playing football and gets a slight concussion—nothing of any observable clinical significance, you under stand—or his father, listening to the football scores in the outlying unreconstructed districts, has one beer too many Suppose neither of them can remember whether they live in Unit B, Floor 13, Apt 1C, or is it Unit Z, Floor 7, Apt. 4?

Imagine the plight of those poor deracin ated blind moles, groping their way from one identical apartment to another. The height of the buildings prevents them even from being able to take a sight on the North Star to orient themselves by means of the heavenly bodies. They were not born with the instancts that the lowliest bee has, to guide him home to his individual cell in the racial honeycomb

We look forward with some uneasiness to the antics of the first generation of children that is to spring from the uniform, standardized, sanitary, up-to-date, healthy, sunny, grass-lawned, playgounded housing units

Aren't there going to be lots of gangsters, exhibitionists, and others of their ilk who will flourish on such safe, sanitary, socially conscious soil—no pun intended—just because there is something in their perfectly normal natures that makes them want—for God's sake—to be a little different?

We end by presenting our readers with the smallest crumb of comfort we can think of The atom bomb may make the question of whether or not we live in a home or in a housing project of no importance whatever

But in the meantime while we, like the Millerites, await the end of the world, doctors might do well to consider the vagaries of conduct they will encounter caused by nothing more abnormal than the desire of the normal human being to exhibit a little individuality of his own

### Current Editorial Comment

State Medicine in Practice The JA-MA reports¹ on the results of a state medical service in operation for some time in New Zealand It will be remembered that on May 14, 1947,² Mr Isadore Falk of the Bureau of Research and Statistics in the Social Security Board urged that one Jacob Fisher, a member of Mr Falk's staff, be sent to New Zealand at government expense to study compulsory health insurance programs and activities in that nation ³ Mr Fisher could profit by the report of the London correspondent of the AMA who writes as follows

Sir Ernest Graham-Little, dermatologist, member of Parliament, and well known as a writer on medical politics, shows in the Daily Telegraph the results of a state medical service in New Zealand, where it was instituted by the labor government and has been in operation for ten years Since the war the system has been fully reviewed in the House of Representatives, and almost universal dissatisfaction with it has been expressed. The complaint was made that it is a common practice for physicians operating the health service to undertake treatment of an impossible number of patients and to push them through at the rate of one every five minutes. If the diagnosis is not conclusive the patients are sent to the public hospitals, which are consequently filled with trivial cases, crowding out serious cases The prime minister, who had a large part in founding the scheme, was so shaken by the evidence that he said "If patients are being treated like sheep passing through a dip, without proper overhaul, the matter should be investigated" In a subsequent debate the minister of health admitted that the abuses of the system were such that the government must seriously consider altering it

Other criticisms have been made For instance, it is contended that, while state doctors draw extravagant incomes from the social security fund, it is extremely difficult to secure any medical attention outside business hours or during the week end. There is said to be a definite falling off in the standard of medical practice, from both the ethical and the clinical points of view. The absence of incentive to undertake the prolonged training to qualify for the status of specialist has resulted in a serious dearth of skilled physicians and surgeons and consequent discouragement of both medical research and postgraduate study

The cost of the security benefits has mounted sharply During the year ending March 1 it was \$139,000,000 against \$83,000,000 for the previous year. The drug bill increased from \$2,250,000 in 1943 to \$5,700,000 in 1947 and the medical benefits from \$4,000,000 to \$7,000,000 in the same period.

It is to be recalled that Life Magazine, in discussing editorially "The Public's Health," a review of the current proposals for the British brand of State medicine (National Health Service), remarks that

Vol 135 No 7 Oct. 18 1947 p 447
 80th Congress 1st Session, House Report, No 786 p 7
 New York State J Med , 47, 1976 (Oct. 1) 1947

<sup>&#</sup>x27;Sept. 1, 1947, p 28

"New Zealand has found that under a system of socialized medicine the tendency is for the doctor to encourage unnecessary consultations to collect more capitation charges And some patients, freed of direct payment, tend to malingering and hypochondma

The whole picture is a sad one tably the public which must pay for the mevitable heavy costs of such schemes with their deteriorated, diluted, superficial, medical lip service, "patients being treated like sheep passing through a dip," will probably have to learn the facts the hard way

The Hog in the House A correspondent writes, via the Secretary of the Medical Society of the State of New York, a sorry tale of human misunderstanding doctor correspondent engaged a locum ten ens, Dr A, under the following circumstances

Answering an advertisement in the New YORK STATE JOURNAL OF MEDICINE, I explained to Dr \ that I had worked hard through thirty years, active in one war and overworked in the second, and wanted a long rest and also wanted an associate to take over largely my medical work and, ultimately, perhaps very soon, my house and office He came here with that understanding was introduced to my pa tients without reserve as "the doctor who would be associated with me on my return "

To make a long and unpleasant story short, before my return he bought and advertised the opening of his own office and has stayed

right here

He had the use of my home and office histories and car-the latter incidentally left

practically useless

I fully realize that according to law one should have a written agreement or contract, there are many unwritten rules of conduct especially in medicine, that are recognized as lived up to daily by all honomble physicians

In our own defense we can only say that we are interested and eager to offer professional opportunities to our colleagues who are desperately in need of them doctor himself admits that he should have had a guarantee in writing from his locum tenens that he would not do any of the things he subsequently did We believe that he has not necessarily cut the legal ground from under himself, and has a basis for suing the cuckoo in his nest if he can convince a jury that a verbal contract was made

Acknowledge it or not, as you choose there are some "cuckoos" in any profession Indeed, with the extraordinary opportunities in medicine for charlatanry, drug peddling euthanasia, etc., we frequently congratulate ourselves that the profession is as clean as it is

But even so, it is not nearly so pure as it

might be

The medical profession has proudly proclaimed its ability to police itself, on the ground, we presume, that its ranks were filled by citizens slightly above the average grade of morality

Here is a splendid opportunity for it to show what it can do The community in which the quoted incident took place is a comparatively small one The local newspaper printed an extensive announcement of the arrival of the 'cuckoo' in its com munity If the county medical society held a special meeting for the purpose and passed a resolution condemning the conduct of Dr A, the newspaper might be persuaded to print that, too

Small, and even larger communities, have achieved results by "putting the freeze" on Dr X will undoubtundestrable citizens edly attempt to justify himself by pointing to his unselfish service in the last World How about his employer's service in War World War I, and his overwork at home in

World War II?

Here is the case of a reputable member of the medical profession who invited a colleague-literally-into his home, entrusted him gratuitously with every professional neapon that he possessed, because he had so much trust in the honor of a member of his profession that it never occurred to him to insist upon a legal written contract And, returned from his "vacation," found himself, after many years of service, betrayed

It is admitted that the law provides no What can the medical profesmon and the decent sentiment of a com-

munity do? Let's see

New Departure in Infant Feeding makes sense to us, however, the Children's Bureau might choose to view it with alarm as another manifestation of private initiative or individual enterprise or something

The 'self-regulating" method of feeding habies 'is consonant with the democratic society of which the children are a part and with basic physiologic laws,' say two mem

bers of the Section on Pediatrics of the Mayo Clinic, Rochester, Minnesota, in the October 11 issue of The Journal of the American Medical Association

The writers, C Anderson Aldrich, M D, who is director of the Rochester Child Health Project, and Edith S Hewitt, M D, who is a member of the same project, base their conclusion on experience with 668 infants whose mothers let them eat as much or as little as they wanted whenever they seemed to be hungry, up to their first birthdays. These comprise all the Rochester babies born in 1944 and 1945 for whom one-year summaries were completed in the well-child clinics of the Rochester Child Health Project, which supervises mothers of all economic groups in feeding and caring for their babies after dismissal from the hospital

The mothers were told what kinds of food to offer their babies, but otherwise their chief role was to supply the food and to discover their offsprings' individual rhythm of eating. They were instructed to offer changes in the types of food and the methods of feeding whenever the babies showed that they were able to swallow semisolids or to chew solids, or began to reach for cup and spoon. But bottle feeding was also to be continued until the new methods were firmly established, or until the baby began to reject the bottle.

The infants were even allowed a good deal of freedom in choosing between foods which have similar nutritional value, such as the different vegetables and fruits. Mothers were advised to give, at most of the feedings, types of food which the babies preferred rather than to try to broaden the menu in spite of the babies' resistance.

The attained heights and weights of the babies at one year of age compared favorably with the generally accepted standards, 29 4 inches and 21 8 pounds

A group of 100 infants were also studied more intensively in order to determine the feeding interval they preferred Forty of them were breast fed for several months, and 60 were artificially fed

At one year of age 91 per cent of the babies had automatically placed themselves on a regimen of three meals a day, the doctors noted that "in the early weeks of life a large majority of the babies chose an interval of less than four hours"

"Whereas a rigidly prescribed routine of feeding intervals could meet the requirements of the average baby," the doctors point out, "it could not possibly fit the needs of those whose natural rhythm deviated greatly from such averages. Both the precocious babies, who tended to lengthen their intervals early in life, and the slower-to-change babies would be out of step."

We commend the authors of this research as well for the sound philosophic concept on which it was founded as for their personal hardihood in provoking the probable feral wrath and indignation of 2,672 grandparents

It must also be realized that the institution of such "liberal" procedures will cause havoc in hospital nurseries and with the timetable methods taught to mothers by our pediatric conferes However, time will tell

Editor Trustee It is of interest to note that a fellow editor of a state society journal, namely that of North Carolina, has been selected to fill the unexpired term of Dr Charles A Roberts, who died some months ago Dr Wingate Johnson has occupied a prominent place, in addition to his editorial accomplishments, in the field of internal medicine He is the author of numerous contributions to the literature, he has been active in the American Medical Association House of Delegates, he has devoted himself more recently to raising the status of the general practitioner Our good wishes go forward to him in his new office as a member of the Board of Trustees of the  ${f A}$   ${f M}$   ${f A}$ 

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# Scientific Articles

#### PREFRONTAL LOBOTOMY UNDER DIRECT VISION

Survey of Psychiatric Aspects

JOHN E SCARFF, MD, and LOTHAR B KALINOWSKY MD New York City

(From the Neurological Institute)

THE neurosurgical approach to mental illness has reached the stage where it seems justified to give a survey on the subject before a general medical meeting Limited to cases where shock treatment has failed or is not indicated the brain operation represents a valuable addition to our therapeutic armamentarium in many otherwise maccessible cases Careful selection of cases is imperative, and it can be hoped that with better evaluation of individual patients, rather than through large statistics, a reliable preoperative prognosis will be possible in most cases. Close cooperation between neurosurgeon and psychiatrist is a point of great importance as already demonstrated by the originators of the method of Monis and Lima in 1936 and later by the Ameri can pioneers, Freeman and Watts. 1.3 The authors of the present paper followed this pattern closely, one of them (J E S ) limits himself to the neurosurgical problems which particularly regarding the fibers to be cut, are far from being settled, while the other (L. B K) selects and evaluates the material psychiatrically, based on experience with the shock treatments, and tries to integrate the surgical approach with the less drastic somatic treatments at our disposal Some of the authors' own impressions are incorporated in the present paper, which, however, is meant chiefly as a survey on the present status of this new method.

Prefrontal lobotomy or, as it is sometimes called leukotomy, originally was based on the idea that the frontal lobes produced dominant chnical manifestations in the psychoses The intended breaking up of "faulty cellular connec-Watts in their monograph on "psychosurgery, which gives a complete survey on all the theoretical and practical aspects, promote the theory that not only sensations as is generally accepted

tions,' particularly in the frontal lobes, had to be performed bilaterally because each frontal lobe can be substituted by the other Freeman and

but also ideas receive their affective charge in the thalamus by interrupting the connections between the nucleus medialis dorsalis of the thals mus and the frontal lobe, the affective response to certain psychotic experiences or neurotic symptoms is reduced. We feel that this concept is borne out by those patients in whom abnormal ideas or hallucinations continue to be present but no longer worry the patient. It is more difficult to explain those patients in whom the symptoms disappear entirely. As a working hypothesis in establishing indications and prognosis in individ ual cases Freeman and Watt s hypothesis has proved itself to be extremely valuable to us

Prefrontal lobotomy is performed by transecting the white matter of the frontal lobes bilater ally in the plane of the coronal suture This keeps the cut in front of the lateral ventricles question of which part of the connections between frontal lobes and thalamus should be cut to assure clinical results is still disputed and Watts emphasize the importance of cutting the fibers near the middle line. Hoffstatter et al.4 cut exclusively the orbital areas in order to diminish the side-effects of the operation How unsettled this question of the optimal arte of the cut still is was demonstrated by neuropathologic studies of Meyer and Beck, who showed in seven autopsies that incomplete severance of the thalamofrontal fibers in quite different planes gave equally good clinical results. In some instances with unsatisfactory outcome reoperation was performed and a further cut of fibers achieved the desired result.

The technic developed and standardised by Freeman and Watts is now generally in use throughout the country These workers make a small trephine opening at a point 3 cm. behind the lateral rim of the orbit and 6 cm. above the sygoma Through a small opening here a long narrow blunt dissector is mserted directly into the brain in the plane of the coronal suture and is awang downward until the floor of the anterior force is reached, then carried along the floor as far laterally as the opening will permit. It is

Prescated at the 141st Annual Meeting of the Medical Society of the State of New York, Buffalo Section on Neurology and Psychiatry May 9 1947

then reinserted and swung upward and along the convexity of the brain. The fibers of the upper and lower parts are then severed on both sides

This method recommends itself for its technical simplicity. However, it is open to the objection, theoretical and real, that blood vessels may be torn open with considerable hemorrhage into the brain which is unrecognized at the time and uncontrolled, and this factor in turn may not only increase the postoperative morbidity and even to some extent the mortality, but it also makes unpredictable anatomic and pathologic changes in the brain, which are undeterminable

#### Technic

To offset these objections, the authors have been performing the section of white matter under direct vision, as also recommended by Lyerle 6 Sodium pentothal intravenously in conjunction with local infiltration of the scalp is the anesthetic employed A coronal incision of the scalp is made which crosses the midline just posterior to the coronal suture at a point approximately 14 cm behind the nasion, and passes laterally and slightly forward toward the lateral rim of the orbit, but ending 2 to 3 cm short of that point The anterior flap of scalp is then reflected forward exposing the central two thirds of the coronal suture and the area of the skull immediately before and behind it A small osteoplastic flap is then turned up on each side of the midline, "hinged" on the temporal muscle and extending medially to within about 2 cm of the These flaps "straddle" the coronal suture, and he about two thirds in front of the coronal suture and one third behind it

The dura is then opened and a short incision, approximately 2.5 cm in length, is made through a suitable area of cortex in the line of the coronal suture or immediately anterior to it. The edges of the incision are held apart with a narrow spatula applied to the anterior wall. The position of the anterior tip of the ventricle is determined with a ventricular needle, thereby establishing a plane for section of white matter, which is essentially that of the coronal suture but which passes just anterior to the tip of the ventricle

The actual "section" is made by gently sweeping the tip of a very fine metallic sucker tip in the plane desired. The white matter is easily divided

by the metallic tip and the field is kept dry at all times by the suction. As vessels appear in the field they are first cauterized or clipped, and then divided. Vessels which are accidentally divided are easily picked up and cauterized or clipped. Proceeding in this manner, bleeding is either prevented or immediately controlled, and the entire section proceeds in a surgical dry field under direct vision at all times.

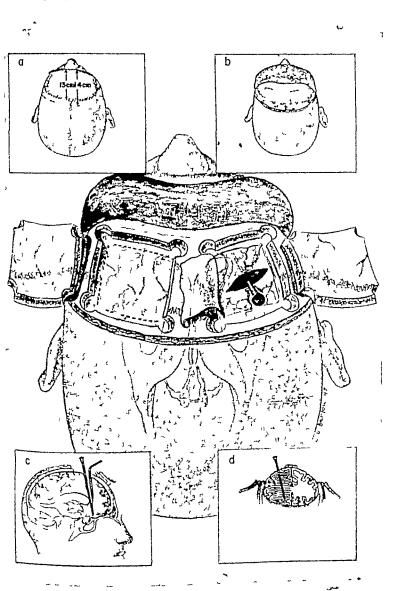
The section is extended radially within the selected plane until gray matter of the medial, lateral, and inferior surfaces of the frontal lobe is reached, and to a line 15 cm from the floor of the frontal fossa, as measured by a ventricular needle Silver clips are placed at intervals around the periphery of the "section," for subsequent x-ray reference. If the ventricle is opened accidentally, no apparential effect results, and no special management is required. The dura is then resutured, the bone flap replaced, and the scalp closed

Leukotomy under direct vision assures a mini mal operative mortality and postoperative morbidity Little change, if any, occurs to the patient's pulse rate or blood pressure during the The anesthetist's chart is usually "flat" Within a few hours after operation, the patients are usually responsive and fairly well oriented The following day, as a rule, they take their normal diet with apparent pleasure this time most of them are quite alert and communicative They begin looking at newspapers or magazines and start "reading" shortly thereafter The postoperative temperature is rarely elevated for more than twenty-four or forty-eight hours Stitches are removed on the third postoperative day and the patient, as a rule, is out of bed by the These patients mingle sixth or seventh day with the other surgical patients, although, of course, they are always in the company of a nurse or attendant They are usually discharged from the hospital within ten to fourteen days after the operation

# Postoperative Course

The first days or weeks after the operation may be disconcerting, but it cannot be emphasized sufficiently that nothing we see during this period gives any clue as to the final outcome of the case. Much prejudice against the operation re-

Fig 1 (see next page) Prefrontal lobotoms —technic used by authors A coronal incision is used, placed just behind the coronal suture (a) The scalp is reflected off the frontal bones (b) Small osteoplastic flaps straddling the coronal suture are turned up on each side of the midline (center) A small incision is made in the cortex parallel to, and slightly anterior to, the coronal suture (center) The anterior poles of the ventricles are located by means of a ventricular needle (center). The plane of the leukotomy corresponds approximately to the plane of the coronal suture, but is established far enough forward to miss the ventricles (c). The base of this plane falls approximately at the line of the sphenoid ridges (c). The white matter within this plane is divided with a fine metallic sucker until the gray matter is everywhere encountered at the periphery of the section (d).



sults from the fact that those having no personal expenence fail to distinguish between transitory, immediate postoperative manifestations, and permanent effects The much discussed regression to the behavior of a child characterizes the transitory postoperative state while the actual loss of higher psychologic functions is minimal Deep confusion, rare in our experience, obviously is not necessary for a good result

Numerous postoperative changes have been Rather frequent is an increase of described temperature which may reach 102 F, and last for several days. After the operation the patients develop an enormous appetite and eat indiscriminately everything offered to them Gain of weight is almost constant and sometimes reaches a degree which is better explained by endocrine dysfunction than by the increased intake of food Changes in autonomic regulations are frequent Focal neurologic signs, mentioned by Moniz and Lima, were hardly seen by other workers It is only during the later postoperative period that convulsions occur, Fleming, in a review, reported their occurrence in 64 per cent, but they are often a transient occurrence 7

Inertia is the leading symptom for days and weeks. Even if the patient is perfectly clear he shows no spontaneity When spoken to, his answers come quickly and without much thought He does not care much about his answers He is indifferent and inattentive He will soon look at books, but has no understanding of what he reads Repetitiousness and playfulness are other characteristics of this period His productions in writing or drawing are primitive, like those of a

The most disturbing feature for the onlooker is that the patient is entirely unconcerned about everything This is best emphasized by the way he reacts to the frequent, but by no means constant, symptom of incontinence of urine and, sometimes, of feces Incontinence of urine at night is often seen for several weeks, although during the daytime the patient soon learns to control his excretions The mental state hardly explains the incontinence as such, but the patient's complete lack of humiliation for his incontinence makes re-education more difficult

As to the symptoms for which the patient was operated upon, the same is true as for the sidewhatever we see during the first few weeks is not indicative of the future develop-Certain symptoms may still continue for some time, but they have a different meaning A patient who before the operation tried to scratch out her own and other peoples' eyes still tried to touch eyes for several days after the operation, but without any aggressive tendency and more playfully Serious symptoms often change into

harmless habits The same is true for compulsive acts which the patient may still perform. he does not even fight his compulsions which become unimportant to him and which are slowly given up Most complaints are forgotten, and ag gressive and self-destructive tendencies are gone.

Care of the patient during those first postoperstive weeks is an important part of the planning of the operation We keep the patient at the Neurological Institute for eight to twelve days only, but request that the family make arrangements for a two months' stay in a private samtarium where one of us supervises his re-education following his discharge from the Institute The symptoms which must be overcome during this period are mertia, tactlessness, lack of inhibit tions, and other "organic" symptoms It is not easy to determine how much active re-education really accomplishes The patient is usually will ing and open to suggestion, but he does not take The disturbing admonitions very seriously symptoms improve slowly by themselves let hospitalization of two months should be insisted upon One patient against our advice was taken home prematurely by the highly pleased relatives, he took alcohol to which he was obviously intol erant like any other "brain-injured" patient, became threatening, and had to be taken to an institution He is now fully recovered There is no doubt that careful planning is extremely important for a fully successful prefrontal lobotom), and possibilities of rehabilitation should be discussed by the psychiatrist and with the help of social workers even before the operation It should be stressed, however, that if competent care in a private hospital is not feasible, the pa tient should be kept for at least two months in a public institution rather than taken home, because he needs constant supervision for his own protection

Lasting side-effects seem to be fewer than originally thought They are difficult to judge m schizophrenics, because the organic symptoms after a brain operation and the defect state of a chronic schizophrenic have been symptoms in The most important of them is emotional duliness Lack of tact and other signs of impaired feeling for finer distinctions, often seen in operated patients, also can be observed in schi Psychoneurotics after zophrenic remissions operation are better test objects for judging the side-effects of the operation, and it is striking how few of the much discussed after-effects of prefrontal lobotomy are present in the majority of cases Slowness of performance is often com pensated by greater attentiveness, because the patient is less preoccupied than before Impair ment in the emotional sphere can be assessed

less easily by tests

Is mtelligence impaired after prefrontal lobotomy? Most workers agree that with the usual testing of psychometric intelligence the LQ remains within preoperative figures. It has been realized for a long time, however, that the IQ gives a picture of only certain abilities and does not include all parts of what Halstead called 'biological intelligence.' Special intelligence tests decised by Halstead show that only after removal of cortical tissue of both frontal lobes is there any impairment, while these tests after prefrontal lobotomy, with only white matter being cit, do not show any significant impairment of intelligence.

There is frequently an increase in intellectual shilties following prefrontal lobotomy. This is easily explained in those patients in whom the synhotic state or neurotic preoccupation had prevented the patient from using fully what intelligence he had. According to I recention and Watts it is not the intelligence as measurable by tests which is impaired but the functions of foresight and insight, a Viore work is needed particularly with examinations regarding impairment of "abstract attitude" (Goldstein). The practical conclusion however, can be made that fear of intellectual deterioration should not withhold the operation from any patient who is afflicted with a disabling psychiatric condition.

#### Indications

Prefrontal lobotomy is not specific for any single psychiatric condition. It is primarily a method to remove certain manifestations of psy chaine conditions. Rees lists as the symptoms most reliably removed anxiety groundless fears about the future, suicidal tendencies, self mutila tion, states of tension, destructiveness, and attacks of uncontrollable violence . Patients without emotional response to their symptoms will not benefit from the operation The success, actording to Freeman and Watts, can be anticipated in proportion to the manifestations of emotional tension 1 It is obvious from these statements that patients with the most varying psychi atric disorders can be benefited A thorough Psychiatric evaluation of each individual case is necessary to determine the desirability of the operation.

The two types of patients primarily suitable for prefrontal lobotomy are schizophrenics refractory to shock therapies, and obsessive-compulsive neurotics who remain uninfluenced by hyphotherapy. A number of other psychiatric syndromes present less definite indications

Schnophrenta.—The scriousness of the schnophrente psychosis and the great number of hopeless chronic cases in this group explain why the decision to operate on the brain was more readily

made in this than in any other group It should be emphasized, however that it is a mistake to delay the operation until the patient is hopelessly deteriorated Although we strictly limit the operation to schizophrenics who have failed under all available methods of shock therapy it is ad visable to operate as early as possible after the shock treatments have failed. It is striking to see how different is the outcome after a prefrontal lobotomy in a schizophrenic psychosis of one or two years' duration compared to patients who have been ill for five or ten years. Emotional duliness, loss of mutiative and certain thinking disorders are irreversible changes in a chronic schizophrenic psychosis and cannot be expected to disappear, and it is a mistake to blame the surgeon for symptoms which are caused by the longstanding psychosis rather than by the surgical intervention

It is obvious that early operation will largely diminish residual symptoms.

It is still unknown how far the basic schuzophrenic process is touched by the operation, but it is underiable that most of the disturbing symptoms can be removed Violent behavior, suicidal and homicidal tendencies and destructiveness disappear in the majority of cases. Hallucinations and delusions often continue to be present but the patient no longer reacts to them. The types of schizophrenics usually uninfluenced are emotionally empty hebephrenics without "active" symptoms, and withdrawn catatonics. We do not accept these groups for the operation The statement by Freeman and Watts that the emotional responsiveness is the most important prognostic criterion for prefrontal lobotomy was found to be extremely valuable in our experience

Social considerations are of great importance. It is of questionable value to change an institutional patient into a mental invalid living at home for whom the family has to care for years to come. Yet there are instances where the relatives have shown by constant unsuccessful attempts to take the patient home that they are willing to bear any sacrifice as long as the patient is with them. In such cases even a deteriorated patient may be accepted for the operation.

The statistical evaluation of prefrontal lobotomy in schizophrenia encounters even more difficulties than that of the shock therapies. Attempts should be made in statistics to correlate duration of illness and results. Stricter selection of cases makes for higher improvement rates. On the other hand, the results in mental institutions, which mostly operate on deteriorated disturbed patients, are statistically poor, although it may be a highly gratifying result when a chromically disturbed bomicidal patient, who has been constantly in restmint changes into a harmless

and pleasant, though still dull and mactive, institutional patient

It has been rightly stressed by most workers that no patients are made worse by the operation, and it is regrettable that physicians not acquainted with the method often warn against the operation with just this statement. The vast majority of cases improve after operation, and in those where even violent behavior and destructiveness remain uninfluenced, it must be assumed that not sufficient fibers were cut, and reoperation should improve the result

In conclusion it can be said that in the fight against deleterious effects of schizophrenia prefrontal lobotomy is an extremely valuable weapon when it is combined properly with other available somatic methods. Results will be most satisfactory when the operation follows without further delay the unsuccessful application of electric shock therapy, insulin therapy, and combined shock methods. A clear plan for treatment should be outlined as soon as the diagnosis of schizophrenia has been made, and then followed through systematically in each individual case.

Obsessive-Compulaive and Other Neuroses ---There is increasing evidence that disabling psychoneurotic syndromes represent an excellent field for prefrontal lobotomy The most recent statistic by Freeman and Watts shows that in obsessive states all patients showed good or fair results, although in some this result was achieved only after a second operation Most workers agree with this favorable impression It is obvious that physicians will be more reluctant to operate on the brain of an intellectually unimpaired psychoneurotic than in a schizophrenic, and therefore, fewer figures are available for this group sults are particularly good in severe incapacitated obsessive-compulsives What has been said about adequate shock therapy in schizophrenia prior to the operation should be emphasized regarding intensive psychotherapy in the psychoneuroses The danger that delay of the operation might interfere with results does not exist in this group and it will depend on the judgment of the psychiatrist when psychologic methods should be replaced by surgery It is surprising to see how few sideeffects after the operation are recognizable in most psychoneurotics compared to schizophren-Some loss of initiative, affect, and sense of finer distinctions occasionally worry the relatives, but they do not interfere with the patient's happiness compared with the constant suffering prior to the operation, and complete social readaptation is frequent

Other Conditions—Little experience is available in other psychiatric conditions with the exception of the involutional psychoses. Pure involutional melancholia responds to electric shock

therapy in practically all cases, and it is our one. ion that surgery should be limited to the rare failures under shock therapy The reviews by Walker, 10 and Brody and Moore 11 show that results are contradictory The same can be said about the manic-depressive psychoses where little information is available as to whether or not future episodes of this recurrent disease can be prevented The paranoid type of involutional psychosis usually was not separated from involvtional melancholia in available statistics. The paranoid group, more closely related to schize phrema than to the effective disorders, is a promusing field for prefrontal lobotomy, all the more as these patients respond poorly to shock thempy The strong emotional response to their delusions, which brings them into conflict with somety, can be removed by the operation even if some of the delusional ideas persist. These patients, who are seldom deteriorated, often make an excellent social adjustment after the operation

Other psychiatric disorders may become subject to the operation in individual cases Tenson or depressive mood were reasons for operating on alcoholics, irritability and violence led to surgery Reports on operations in psychoin epileptics pathic personalities with and without criminal Neurologic conditendencies are controversial tions such as parkinsonism when complicated with mental symptoms were operated upon with Finally, Freeman and Watts varying results operated successfully on various patients with intractable pain, and Van Wagenen saw rebel from pain in the case of a phantom limb 12

# Summary

The neurosurgical procedure of prefrontal lobotomy is an important advance in the treatment of certain psychiatric cases which have failed under other forms of treatment

The danger of the operation is small and can be lessened further by operating under direct vision, thus permitting full control of bleeding

A technic for prefrontal lobotomy under direct vision is described

Permanent intellectual impairment is absent in psychometric tests. Spontaneity, future planning, and emotional response show some impairment which is not such as to be considered a senous objection in the type of cases for which the operation should be reserved.

Schizophrenics who have failed under adequate shock therapy are good prospects as long as strong emotional response to their psychotic experiences is still present. Duration of illness is an important factor for the outcome and the operation should be performed as soon as possible after all available shock treatments, adequately applied, have failed

Obessive-compulsive patients and some other severe neurotics who were not responsive to in tense psychotherapy returned to useful and pleasant lives.

Other psychiatric disorders may also be suit shie for the symptomatic effects of the operation

Reports of individual cases rather than large statistics will add to our understanding of the possibilities of prefrontal lobotomy

#### Discussion

Dr Paul Hoch, New York City -I believe at the present stage of our knowledge it will be necessary to agree on a basic principle namely in which psychiatric cases this procedure should be advocated indiscriminate use of frontal lobotomy would discredit this method quickly Therefore, it will be necessary to define rather sharply where this operation should be used. This naturally should not prevent experimentation with the operation but experimentation done for research purposes should not be confused with its use generally We believe that, at present, it should be employed only on chronically ill patients, in other words, in individu als who have been mentally sick for several years In addition, it is necessary to request that these patients receive all other available treatments before operation is performed. In psychotic patients they should have been exposed to insulin and electric shock therapy In neurotic patients they should have received competent psychotherapy of an adequate amount before the case was judged ready for operation. It seems to me that prefrontal lobotomy is not a therapy for certain diagnostic entegories like manie-depressive psychosis or schlzophrenia, but a procedure especially helpful in cases where phobic anxiety or obsessivecompulsive symptomatology dominates the clinical picture. In addition it can be used in very disturbed and destructive chronic schizophrenic patients where the operation will alter the attitude to their environment, causing them to become more amiable and complacent, even though in these patients a change in the general psychotic structure cannot be expected. Chronic depressions which have resisted shock therapy are also suitable for frontal lobotomy We are most impressed by the effects of prefrontal lobotomy in some well preserved schizophrenics with phobic and obsessivecompulsive symptomatology and in cases of long standing, obscessive-compulsive neurosis where sometimes the results exceed anything seen until now with other therapies.

In selecting the patients for operation, it is also important to pay attention to their profession. Persoms who did a high caliber intellectual work usually suffer from the operation, and I believe that persons with outstanding intellects should be operated upon only if the sickness they have is so incapacitating that their intellectual capacities however outstanding are not used due to their illness. This brings us to the psychologic observations made on cases with frontal lobotomy If you scan over the psychologic tests they show very little, and actually the impression is gained that the person who undergoes frontal lobotomy shows no intellectual impair ment Clinical observations, however indicate that even though gross intellect is not impaired, fine intellectual functioning, like planning foresight, as it was pointed out by Freeman and Watts and many other subtle functions of the psyche are sufficiently modified in some individuals to be considered crip-Our psychologic tests employed today pling simply are not sufficient to show these changes and most likely tests will have to be devised which will demonstrate these fine psychic alterations fore because the usual psychologic tests indicate very little, it is not permissible to say that important operations of the intellectual functioning of the pationt are not impaired

Frontal lobotomy is most likely a quantitative approach in the treatment of mental disorders Generally speaking, this treatment leaves the basis of the mental disease unchanged but it reduces the impact of the disorder on the patient. For instance, hallucinations obsessive ideas or fears are noticed by the patients after the operation but they say that they are not dominated by them as before and that they gradually fade away How this diminution of the emotional pitch behind the patients symptoms is accomplished and, especially why sometimes intricate obsessive and phobic symptomstology disappears completely is not known and a great deal of further research will be necessary to demonstrate how this is accomplished. Frontal lobotomy is not only an important tool in the treatment of chronic mental disorders but I believe also it will be of great theoretic importance to show how quantitative factors and not only qualitative ones which are supposedly better known, enter into the picture of mental disease.

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# THE EFFECTS OF INFLUENZAL MENINGITIS ON THE NERVOUS SYSTEM

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RECENT years have witnessed several important additions to our knowledge of influenzal meningitis, especially as regards therapy. Newer antibiotic substances promise to reduce significantly the mortality rate from this disease and it will follow inevitably that the amount of material available for pathologic study will be limited hereafter. The time seems ripe, therefore, to examine in detail the lesions of the nervous system. It is only by fully apprehending their nature and extent that the symptomatology, the therapeutic failures, and the crippling sequelae can be viewed in their proper relationship.

Two or three characteristic cases will illustrate the problems which will confront physicians as a consequence of the introduction of new methods of therapy

# Case Reports

Case 1—(BCH A46-85) The patient was a 1-year-old girl who three weeks before admission began to "cut teeth" and seemed less active although she ate well. No other details of the history were obtained except that on the day of admission to the hospital she appeared dazed and did not recognize members of her family. A few hours later she had several generalized convulsions

Examination The temperature was 100 F and pulse was 96 There were convulsive movements of the left side of the body, more pronounced in the leg than in the arm. On the right side the arm was held in flexion and the leg in extension, both were mactive. The eyes moved constantly from side to side and the pupils did not react to light. The patient remained comatose between convulsions. Both ear drums were bulging and the breath sounds were diminished over the right upper lobe.

Laboratory Data The hemoglobin was 52 per cent, red cell count was 329, and white cell count was 36,000 with 90 per cent neutrophils. The cerebrospinal fluid contained 3,086 white cells (nearly all neutrophils), no sugar, a 4+ Pandy and H influenzae in smear and culture. There was no record of a blood culture.

Course Sulfadiazine and influenzal antiserum were given immediately. The cerebrospinal fluid

Presented, by invitation at the 141st Annual Meeting of the Medical Society of the State of New York Buffalo Section on Neurology and Psychiatry May 9 1947 on the second hospital day was unchanged. Come persisted. There was a spirite right hemiplega and the plantar reflexes were extensor on both sides. Death occurred on the third hospital day or four days after the onset of convulsive seizures.

Anatomic Diagnoses Acute influenzal meningits, acute subdural empyema, left, ischemic necrosis of the cerebral cortex of the left frontal, temporal, and parietal lobes, acute purulent otitis media, bilateral

Pathologic Findings There was relatively little evudate in the subarachnoid space over the brain and spinal cord In the subdural space there were approximately 30 to 45 cc of vellowish-white exidate which adhered to the outer surface of the arachnoid obscuring the blood vessels and sulei of the lateral surface of the left hemisphere some depression of the left hemisphere by the eru A small amount of purulent evudate was found in both middle ears and mastoid cells but no direct communication with the meninges was seen There were two small superficial foci of hemorrhagic discoloration, 10 cm in greatest diameter in the right parietal lobe. In the microscopic sections the subarachnoid space contained cellular exudate There was a tendency for this to form two layers, each of different composition outer one consisted of degenerating neutrophils, fibrin and bacteria, and only a few lymphocytes and mononuclear cells, the inner one, which included the pin, was made up of a mixture of neutrophilic leukocytes, lymphocytes, plasma cells, and There was swelling of the intims of macrophages small leukocytes, lymphocytes, and mononuclear The subdural exudate was made up entirely of neutrophils, there was beginning organization next to the inner surface of the durameningeal veins were filled with neutrophils, their walls were necrotic and infiltrated with similar cells. Beneath the subdural empyema there was necrosis of the cerebral cortex, the nerve cells and glia-cell nuclei were shrunken and pale or darkly stained, as in recent infarction. In other less damaged areas nerve cells were thinned out and many rod-shaped microglial cells and "plump" astrocytes were pres-In the subependymal tissues there was interstitial and perivascular infiltration with neutrophils and lymphocytes

Comment The amount of purulent subarachnoid evudate was not very great, and it seems likely
that death was due to the subdural empyema The
latter was an unexpected pathologic finding One
could not tell whether the subdural exudate came
first or was secondary to the meningitis The subdural empyema and the accompanying cortical

damage explained the right hemiplegm and the failure of the right arm and leg to participate in the convulsions. Probably no form of medication, incleding penicillin and streptomycin intramuscularly and intrathecally would have been effective in con froling the subdural infection. The proper treat ment would have been surgical drainage and instillation of streptomy on in the subdural space.

Care 2—(BCII NP 46-10) The patient, a girl aged 10 months became ill two days prior to admission at which time she cried more than nor mally and later became quite drows. On the day before entry she began to vomit appeared pale and slept almost constantly Stiffness of the neck, and a temperature of 103 F were noted later in the day

Examination The patient was a well-developed and nourished infant who breathed rapidly and made frequent high-pitched cries. The temperature was 105 6 F., pulse 150 and respirations 44 She was listless but reacted to painful stimuli. The saterior fontanelle was normal. The neck and back were stiff. Kernig's sign was absent. There was a small area of consolidation in the midportion of the right lung field posteriorly.

Laboratory Data The white cell count on admission was 10,850 with 70 per cent neutrophilis The cerebrorspinal fluid contained 18 250 cells per ci. mm., 80 per cent of which were neutrophilic kulkocytes. The protein was 114 mg per 100 cc and sugar was 20 mg. Direct examination of the fluid revealed gram-negative pleomorphic rods that gave capsular swelling with type B anti influenzal serum. The spinal fluid culture was positive for type B H influenzal serum. The blood culture was positive for type B H influenzal serum.

Course. Treatment with streptomycin started immediately after admission. One hundred thousand units of streptomycin were given intra muscularly every three hours for five and a half Then after a recess of two days with no intramuscular treatment 1 200 000 units were given in thirty hours. Fifty thousand units of streptomycin were injected into the spinal canal on admission and 25 000 units were given once every twenty four hours thereafter for the next ten days By the fifth day the temperature reached a normal level and the blood and spinal fluid were sterile but come and muscular twitchings which had developed on the second hospital day porsisted. On the fifth day a pure culture of Staphylococcus aureus was obtained from the nose and throat and was isolated each day thereafter On the eighth day the temperature rose to 102 F and bilateral bronchopneumonia was discovered on x ray examination of the chest. Penicillin 15 000 units every three hours, was given for the next four days. The temperature remained elevated, coma persisted and the convulsions became more severe. Blood cultures grew out Staph, aureus the last two days of life. The cell count of the spinal fluid was 288 of which 46 per cent were neutrophils, the sugar was 52 mg. and protein 38 mg, per 100 cc. The patient died on the twelfth hospital day or fifteenth day of illness.

Analomic Diagnoses Acute influenzal meningitis undergoing resolution thrombophilebitis of cerebral cortex bronchonneumonia.

Pathologic Findings There were only a few small peckets of subarachmoid exudate along the superior surfaces of the corubral homispheres. They were 0.5 to 1.5 cm. in diameter and 0.2 to 0.3 cm. thick and surrounded the bridging volus. Elsewhere only a slight cloudiness of the arachmoid mombrane was discernible. The upper part of the Rolandic vein in each hemisphere was filled with a mottled white and reddlsh-brown thrombus. The ventricles were not cularged and there were no herniations of the temporal lobes or corobellum. Cultures of the subarachmoid exudate were negative.

In microscopic sections of the brain stem and spinal cord and the overlying leptomeninges only scattered small collections of lymphocy (se and histiocytes were seen. The collections of purulent subarachnoid condate consisted of degenerating neutrophil leukocytes and numerous lymphocytes plasma cells and macroplinges. Bacteria were not seen. Several meningeal veins were filled with partially organized thrombi and in the adjacent correbral cortex nerve cells were completely destroyed in some places and were diffusely thinned out in others. In these areas astrocytes were increased in number and there were many picomorphic or rod-shaped microglial cells

Comment. Even though the menungius apparently had been controlled by streptomycin therapy the patient died. The important causes of death were probably staphylococcus septicemia, pneumonia, and convulsive sciences. The latter very likely resulted from thrombophishitis of cerebral veins of consequent ischemic necrosis of the cerebral cortex. It is possible that the poeumonia occurred as a result of the convulsive sciences and coma, and perhaps might have been prevented by more effective anti-convulsant therapy

Case 5—(BCH 1089472) The birth and early development of the patient, a girl aged 0 months, had been normal and there were no serious illnesses until ten days before entry when she began to take her feedings poorly and had nasal obstruction and cough. Seven days before entry she was listless, had a temperature of 103 F and vomited several times. There was a moderately severe diarrhea for two days. Four days before entry the patient had several convulsive securics and became unrespon ave Because the fever did not respond to oral sulfadiasine she was admitted to the hospital.

Examination. The temperature was 104 F pulse 140 and respirations 48. The patient lay quietly in her crib took no notice of her surround ings, and had a stiff neck with slight head retraction. The anterior fontanelle was still open and was movements were normal. Both arms and both legs were withdrawn from pin prick, which also caused whimpering. The plantar reflexes were equivocal, and the examination otherwise was negative

Laboratory Data White blood count was 18,600 with 92 per cent neutrophils. The cerebrospinal

fluid was cloudy and contained 8,600 white cells per cu mm., nearly all neutrophils, a sugar content of 22 mg, and protein of 186 mg. Type B, H influenzae was grown in cultures of the spinal fluid and blood

Course Fifty thousand units of streptomycin were given intrathecally each day for fifteen days, and on alternate days for another week. hundred thousand units were given intramuscularly every eight hours for twenty-one days The blood and cerebrospinal fluid cultures became sterile, the cells in the cerebrospinal fluid were greatly reduced in number and the sugar content rose to 60 mg. There was not, however, a corresponding improvement in the clinical condition. Although the temperature gradually returned to normal, the patient remained stuporous and continued to have occasional convulsive movements of the left leg and sometimes of the left arm Streptomycin therapy was discontinued after the twenty-second day in the hospital. At the end of two months the temperature and cerebrospinal fluid were normal. The head had enlarged 2 cm. in circumference The patient was stuporous She was startled by a loud noise and would stare at a light which she sometimes followed The optic disk margins were indiswith her eyes The pupils reacted to light and there was The left arm and leg were moved no strabismus much less than the right The left plantar reflex was extensor, the right was equivocal The stiffness of the neck had disappeared

Clinical Diagnoses Influenzal meningitis, healed, severe cerebral degeneration, ? thrombosis of cerebral veins, internal hydrocephalus

Comment In Case 3 the infection of the meninges was controlled and the patient survived, but was left with signs of a severely damaged brain. Convulsive seizures occurring for four days before admission to the hospital suggest very strongly that the brain had suffered considerable damage before treatment with streptomycin was begun

#### Discussion

In times past influenzal meningitis was almost invariably fatal. With present day therapy many of the patients survive and some of them have residual signs of a severely damaged nervous system. In one of the cases reported above and in others which we have observed, even though the meningeal infection was controlled, the patient died because of the development of some complication such as thrombophlebitis and ischemic necrosis of cerebral cortex or associated conditions, e.g., subdural empyema, pneumonia, etc. Thus, because of the greater efficacy of therapy, several new clinical problems arise

The following summary is based on a study of cases 1 and 2, above, and 12 other fatal cases of of influenzal meningitis. Six of these cases were from the Boston City Hospital, occurring among 2,661 autopsies, and 8 cases were from the Massachusetts General Hospital where 3,875 autopsies were performed during the time of the occurrence

of the influenzal meningitis. The clinical data and the pathologic findings in these 14 cases are presented below. For convenience of description the cases were classified as acute (one to fourteen days), subacute (two to four weeks), and chronic (more than four weeks) purulent meningitis. Five of the 14 cases were acute, 4 were subacute, and 5 were chronic.\*

# Symptomatology

As pointed out by others, influenzal meningtis is a disease of infancy and early childhood. Nine of our 14 cases were 1 year of age or less and the oldest of the other 5 cases was 7 years.

The initial symptoms of the disease were almost indistinguishable from those of other severe acute infections in infants. In 7 of our 14 cases the illness began with symptoms of a respiratory infection, i.e., coryza in 4, pharyngitis and tonsillitis in 2, and pneumonia in 1, and in these it was sometimes impossible to tell just when the meningitis began. Others media was known to have been present before the onset of meningitis in 1 case and was discovered during the course of the illness in 6 others. In 3 cases there were no indications of an antecedent infection and the first symptoms were those of meningitis.

One of the earliest and most prominent symptoms was an altered state of consciousness, varying from drowsiness to stupor and coma Another was convulsions. Headache was a complaint in only 1 case, that of a 7-year-old boy, all the other patients were too young to tell of this or other subjective symptoms.

Temperatures varied from 100 to 104 F., pulse rates from 130 to 180 per minute, and respiratory rates from 30 to 60 per minute. Stiffness of the neck was observed in all but 2 cases, as in other cases of meningitis in infants it was seldom as pronounced as in older children or adults. Kernig and Brudzinski signs were usually absent unless stiffness of the neck and spine was pronounced.

Other neurologic signs were noted in 7 of the 14 cases Deviation of eyes to one side occurred in 3 cases, in 2 of these it was probably part of a unilateral convulsion. There was an external rectus paralysis in 1 case. Hemiplegia was observed in 3 cases. In at least 8 of the 14 cases convulsions occurred at some stage of the illness. Usually they were unilateral, often being restricted to the face, arm, or leg. Separation of sutures and enlargement of the head were observed either during life or at autopsy in 5 cases. In the late stages of the illness, stupor or coma invariably prevailed. Blindness and deafness

<sup>\*</sup>A fuller account of these cases is being published else

were not observed, but could easily have been overlooked in an infant or because of coma.

The onset of the illness was seldom as sudden or fulminant as in meningococcus meningitis. All except one of the patients survived for at least three days. There was, however, a remarkable variability in the course of the disease. In some cases the onset was so insidious that it could not be dated and the infant may have appeared well several days after the diagnosis of meningitis had been established. Nevertheless if the patient did not respond promptly to therapy, there was a gradual physical decline and death. Inadequate intake of food and fluids led to severe nutritional disorder, anemia, and emaciation, which were undoubtedly contributory causes of death

It was not possible for us to evaluate adequately different methods of therapy viously in this series all forms of treatment were unsuccessful The cases were collected over a period of years and various forms of treatment were used Judging from the clinical course and the amount of infection found at autopsy both immune serum and sulfonamides sometimes had a favorable influence on the clinical course We have received much less pathologic material since the advent of streptomycin The use of intrathecal and intramuscular streptomycin appears to be the most effective means of controlling the infection at the present time

The significant laboratory data were as follows the cell counts in cerebrospinal fluid ranged from 1,330 to 17,760 per cumm with an average of about 6 000 and the predominant cell was the neutrophil leukocyte. The influenza bacillus was identified by smears and cultures of the spinal fluid in all cases, if typable it was usually type B The sugar levels varied from 0 to 34 mg per 100 cc and the protein ranged from 55 to 655 mg

There was a neutrophilic leukocytosis in the blood ranging from 10 000 to 42,000 Blood cultures were positive for H influentate in all except 2 cares.

# Pathologic Findings

The nature and distribution of the lesions found at autopsy differed considerably from one case to another Many of these variations could be correlated with the duration of the illness, but other less tangible factors, such as virulence of infection resistance of the patient, and effects of treatment, must be invoked to explain some of the differences

In the acute cases of meninguis there was an abundant subarachnoid exudate over the brain and spinal cord. As in other types of purulent meninguis it was usually greatest in amount over the base of the brain and dorsal surface of the

spinal cord Occasionally there was a thick accumulation of fibrinous exudate in the spinal and crainal subarachnoid spaces sufficient to block the flow of cerebrospinal fluid. In 1 of the cases (Number 1 above) there was only a relatively slight amount of subarachnoid exudate but a large subdural empyema. In 1 of the acute cases, thrombophlebrits and ischemic necrosis of the cerebral cortex had occurred, in 1 there was slight dilation of the ventricles, and in the other cases hydrocephalus was conspicuously absent. Cerebellar hermation was present in 1 case.

In the more chronic cases the subarachnoid exudate tended to accumulate in greater amounts around the brain stem. Subdural empvema was present in 1 of these cases and a slight fibrinous exudate on the inner surface of the cranial dura was found in 2 others. Hydrocephalus of slight to moderate degree occurred in all except 1 case.

The microscopic changes in these cases were even more interesting than the gross findings. The extreme variability in the duration of the disease, from eighteen hours to seventy-aix days, afforded an opportunity to trace the meningeal infection through different stages. The following is our interpretation of the disease process based on a study of the pathologic findings.

The earliest observable changes are the hyperemm of meningeal vessels and the presence of neutrophilic leukocytes and of blood proteins, including fibrinogen in the subarachnoid space. The neutrophilic leukocytes increase greatly in number and infiltrate the pia and arachnoid, the cellular exudate extends into the sheaths of cranial and spinal nerves and for a short distance beneath the pla into penvascular spaces of the cortex. In a few days many of the neutrophilic leukocytes degenerate and the amount of fibrin increases. Histiocytes, which are found in the very early stages, and lymphocytes, which appear sometime later, gradually increase in relative and absolute number The histocytes enlarge and show phagocytic activity, i.e., neutrophilic leukocytes and lymphocytes can be seen in their cytoplasm. In the latter part of the second week numerous plasma cells appear During the second and third weeks the meningeal exudate is often separated into two fairly distinct layers. an outer one just beneath the arachnoid made up of well-preserved and degenerated neutrophilic leukocytes and a few lymphocytes and macrophages, and an inner one, next the pia, composed of lymphocytes. After the fourth week there is well marked proliferation of fibroblasts. In the later stages of the disease collections of poorly staining neutrophilic leukocytes are often present these resemble small intramoningeal abscesses but are not encapsulated

During the process of resolution the inflammatory cells disappear more or less in the order of their appearance. Neutrophilic leukocytes vanish, macrophages become less numerous, plasma cells are reduced in number, and, finally, only small collections of lymphocytes remain. If resolution occurs during the acute stage, the meninges ultimately become entirely normal, if the meningeal inflammation persists for longer than two or three weeks, there is fibrotic thickening of the arachnoid

In all of the cases changes are found in the In acute cases the enmeningeal arteries dothelial cells are swollen and increased in num-In some cases inflammatory cells are found beneath the intima of the arteries is a common finding in all forms of meningitis, and particularly in more subacute and chronic forms, but it was observed in one of the early cases of influenzal meningitis and was not always found in some of the older cases The infiltrating cells are neutrophilic leukocytes, lymphocytes, and possibly histocytes. The cells seem to enter the vessel wall through foci of necrosis in the adventitia and media In only 1 case was there occlusion of a small artery by a thrombus

Changes in the veins are more difficult to demonstrate because of the thinness of the walls Proliferation of endothelial cells is a common finding, and thrombosis of a vein or venous sinus was seen in 4 cases

In the sheaths and interstitial connective tissue of cranial and spinal nerves there are lymphocytes, plasma cells, and neutrophilic leukocytes, the type of the infiltrating cells being the same as those in the inner layer of meningeal evidate. Degeneration of myelinated nerve fibers with multiplication of Schwann cells, the formation of fatty macrophages, and the proliferation of endoneurial fibroblasts occur rarely.

In some cases there is an evudate in the subdural space, apparently as a result of necrosis of the arachnoid membrane. This evudate may undergo organization by dural fibroblasts. There is also a small amount of exudate in spinal subdural space and, not infrequently, an infiltration of the dura and epidural fat by neutrophilic leukocytes and lymphocytes.

At the beginning of a purulent meningitis very little change can be demonstrated in the brain even though the patient is confused or comatose. In 1 acute case, where meningitis was present for three days before death, the outer layers of the cortex were infiltrated by neutrophilic leukocytes. Since the nerve and glia cells were shrunken and pyknotic, we believed this to be an ischemic necrosis of cortex rather than bacterial encephalitis. After the first week slight but definite hyperplasia of astrocytes and microglial

cells, the latter taking rod-shaped or pleomorphic forms, are present just beneath the pia in the brain and to a lesser extent in the spinal cord. In many cases recent necrosis of parts of cerebral cortex with destruction of nerve cells and ghal cells and vascular and microghal prohiferation occurs. The cortical necrosis probably is related to thrombophlebitis in some cases. Cortical or subcortical abscesses were not found in any of the cases.

Alteration of the ependymal lining of the ventricles is noted in all except the most acute cases. In some the ependymal lining is lacking in places. Subependymal veins usually are surrounded by neutrophilic leukocytes, lymphocytes, and in some of the more chronic cases by plasma cells. These cells are sometimes scattered among activated microglial cells and swollen astrocytes in the subependymal tissues. Infiltration of the interstitial tissue of the choroid plexuses, first with neutrophilic leukocytes and later with lymphocytes, plasma cells, and macrophages, occurs in most cases.

In some of the chronic cases degeneration of the nerve cells of the cerebral cortex is much more obvious, associated as it is with rod-shaped and pleomorphic microglial cells and an increased number of astrocytes, which are swollen and often multinucleated. In some of these cases there is also a hyperplasia of endothelial and adventitial cells of small vessels similar to that seen in an infarct of the same age. Similar changes may be seen in the cortex of the cerebellum and in the hypothalamus. Degenerative changes also are seen in the optic nerves and spinal cord, particularly in the superficial portions.

# Pathogenesis of the Lesions

The exudative reaction in acute meningitis is similar to that seen in inflammations of other viscera and undoubtedly is provoked by bacteria The purpose of this reaction is or their products presumed to be the destruction and removal of the bacteria Degeneration of leukocytes which are believed to liberate thrombin leads to conversion of fibrinogen to fibrin. The fibrin deposit serves to fix the irritant and if it is not soon removed by digestive ferments it will stimulate meningeal fibroblasts Meningeal fibrosis 18 then an indication of a chronic organizing meningitis

The infiltration of arteries by inflammatory cells, which was frequent in influenza and other types of meningitis, is seldom observed in infections of other viscera. Possibly the fact that the adventitia of meningical arteries is made up of an investment of pia-arachnoid accounts for this Evidently bacteria or their toxins can damage more readily the endothelium of the

thm-walled veins than of arteries hence the greater frequency of venous thrombosis,

The explanation of the diffuse changes in the crebral cortex remains obscure. We are of the opinion that this represents a noninfectious encephalopathy and not an encephalitis. It may be produced by a circulatory disturbance, by the proximity of bacteria and diffusible toxins in the subarnchinoid space, or by other factors. The necrosis of cortex and convolutional white matter was almost surely due to ischemia However, we were able to demonstrate thrombi in cerebral venus or venous sinuses in only a few of the cases. Infarction due to arterial occlusion was not observed.

Sections of a cranial nerve, known by clinical test to have been damaged, were not available in any of our cases. Supposedly, a palsy of ocular or facial muscles and sometimes deafness, a the result of an intense inflammatory reaction in the connective tissue sheaths of the nerves. Deafness, of course, may be the result of an infection of the inner car secondary to the men ingits or to otitis media. Blindness was not known to have occurred in any of our cases, but judging from the inflammatory reaction in the meningeal sheaths of the optic nerves the damage to nerve fibers and glial hyperplana just beneath the pia, the mechanism is the same as that which underlies cortical damage

The ependymuts is probably the result of bacteria passing through the ependymial lining and setting up an inflammatory reaction in the subependymial tissues

# Relation of Symptoms to the Lesions

The headache in meningitis is probably due chefly to inflammation of the meninges and quite possibly is augmented by increased intra cranial pressure Head retraction stiff neck and spine, and the Kernig and Brudzinski signs are due to irritation of spinal and cranial nerve roots and the meninges. The only way in which these parts can be splinted and the tension on them released is by extension of head and fection of knees and hips. The muscle contractions which determine the posture are reflex in nature and are maintained by excitation of protective flexor reflexes.1 The stupor coma and generalized convulsions are related unquestion ably to the noninfectious encephalopathy Unilateral convulsions and hemiplegia or other focal neurologic symptoms signify partial or complete necrosis of parts of the cerebral cortex Enlargement of the head or continued elevation of cerebrospinal fluid pressure and hydrocephalus are wholly or in large part due to purulent exudate or adhesions blocking the foramina of Magendie and Lushka, or the subarachnoid space The cause of the cranial nerve palmes is discussed under pathogenesis of the lesions

#### Effects of Treatment

From our pathologic material it is not possible to evaluate the relative efficacy of the different methods of treatment. Although streptomycin has proved to be much more effective than any other substance, our impression however, is that anti-influental serum, sulfonamides, and peniculin all may influence favorably the course of the disease

If treatment is given early, the influenza meningitis often can be suppressed before irreversible damage to the brain has taken place Or, if the meninguts has been present for many days before treatment is started, severe brain damage already may have occurred and death may result from either the meningstas or one of the aforementioned complications. There are how ever, cases which are the exception to this rule where brain leaons develop early in the infection or the opposite, where the patient does not appear very sick even though the infection has been present for a week or two and the treatment results in prompt recovery without residual brain damage In general the best results have been obtained by early and quick acting ther

The proper management of patients with influenzal meningitis entails not only the prompt administration of intramuscular and intrathecal streptomycln but the early recognition and treatment of the various complications described above. Repeated unilateral seizures and hemiplegia are usually due to ischemic necrosis of the cerebral cortex often with thrombophlebitis. and may perast after the temperature and cerebrospinal fluid return to normal the seizures are controlled by anticonvulsant therapy they may contribute to the patient's death. The possibility of subdural empyema should be considered when hemiplems and unilateral sergures are associated with continued fever elevated cerebrospinal fluid pressure and pleocytosis, normal sugar values, and negative culture. The diagnosis can be confirmed by subdural tap and the treatment should be surgical drainage of the exudate and installation of streptomycin in the subdural space. Hydrocephalus, either communicating or obstructive can be detected by frequent measurements of the head and should be treated conservatively (frequent lumbar punctures to reduce cerebroapinal fluid pressure) for several weeks. Usually this will suffice though an occasional case may require a neurosurgical operation. adhesive arachnoiditis with involvement of optic nerves and chiasm, cranial nerves or spinal

cord were not observed in our material but may be expected to occur in some cases

# Summary

The chinical features and pathologic findings of influenza meningitis are presented. The usual clinical picture was a preceding respiratory infection often with otitis media followed by drowsiness, confusion, convulsions, and coma. Fever, stiff neck, impaired consciousness, and convulsions were the earliest and most common signs. Cranial nerve palsies, hemiplegia and unilateral convulsions, and enlargement of the head were often observed in the more chromic stages of the disease. In our fatal cases death occurred in eighteen hours to seventy-six days. Streptomycin seemed to be the most effective thera-

peutic agent In the acute stages the pathologic changes were essentially those of purulent exudation in the subarachnoid space of brain and spinal cord. In the subacute and chronic stages additional findings were diffuse glial changes in the cerebral and cerebellar cortex, and the hypothalamus and optic nerves, perivascular infitrations of subendymal veins, necrosis of the cerebral cortex, thrombophlebitis of subarachnoid veins, and hydrocephalus. Subdural empyema was an occasional finding. The importance of early diagnosis and therapy in the prevention of permanent brain damage is stressed.

#### Reference

1 Fulton John F Physiology of the Nervous System, 2nd ed 1945, New York City Oxford Medical Publications, pp 97-98

# ARMY OFFERS 200 MEDICAL AND 50 DENTAL INTERNSHIPS IN 1948

Two hundred medical and 50 dental internships will be offered by the United States Army in 1948, to be filled by recent medical and dental school graduates The internships will be for a period of one year of active duty

They will be rotating, and will include the follow-

ing services

Medical Internships—medicine, neuropsychiatry, pediatrics and contagious diseases, laboratory, obstetrics and gynecology, general surgery, urology, orthopedic surgery, and ophthalmology and oto-laryngology

laryngology

Dental Internships—x-ray and oral diagnosis, operative dentistry, oral surgery, periodontia, and

prosthetic dentistry

Pay scales for interns as first heutenants will be in accordance with existing regulations covering commissioned officers' pay and allowances. Credit for purpose of pay is given in accordance with length of military service. Subsistence and rental allowances are determined by the marital status of the intern, additional subsistence and rental pay is provided for officers who are married or have other dependents.

Qualifications required for application are

Medical interns—a male graduate of a medical school approved by the Council on Medical Education and Hospitals of the American Medical Association, who is eligible for appointment as a medical officer in the Officers' Reserve Corps of the Army Graduates of foreign schools are not eligible

Dental interns-Citizens of the United States,

graduates of approved dental schools (now completing 4th year of dental training), not over 30 years of age on July 1, 1947, have made no agreement to accept an internship appointment in any other institution, and meet the physical standards for appointment in the Dental Corps of the Army

There will also be 350 fully approved residences for periods of one, two, and three years, depending on the specialty desired and previous experience of candidate, in various Army General Hospitals in 1948 which will include cardiology, contagion and tuberculosis, dermatology and syphilology, internal medicine, pediatrics, physical medicine, anesthesiology, obstetries and gynecology, ophthalmology, orthopedic surgery, otolaryngology, surgery, thoracic surgery, urology, neurology, pathology, psychiatry, and radiology

Qualifications required for application as residents are Regular Army Medical officers or applicants for the Regular Army who are graduates of an approved medical school (a male graduate of a medical school approved by the Council on Medical Education and Hospitals of the American Medical Association, who is eligible for appointment as a medical officer in the Officers' Reserve Corps of the Army—graduates of foreign schools are not eligible) and have completed at least one year of rotating internship in a hospital approved by the Council on Medical Education and Hospitals of the American Medical Association may be appointed as assistant residents, resident or senior resident, whichever is commensurate with their professional background

#### THE INTANGIBLE FACTORS IN THE TREATMENT OF PATIENTS WITH LOW BACK PAIN

With Special Reference to Industrial Patients

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IT HAS long been known, but sometimes for gotten, that all of the factors in any illness cannot be portrayed on a chart on x ray films a laboratory report, or by physical examination There are intangible factors that play a part in every illness. It is every but as important to recognize and consider these as to record and treat the organic aspects of the illness Par ticularly is this true of the patient with trouble with the back. From times remote, the 'loin' psychologically has been one of the most vulner able areas of the body, second only to the nape of the neck and the temple This fact seems to have been overlooked not only by doctors but also by the industrial public.

Since some representatives of industry and the armed forces feel that the surgical results in the insured patient with ruptured nucleus pulposus are not favorable from their point of view, some explanation must be forthcoming, and, if true, measures taken to correct this There is no question in anyone's mind that the problem of caring for patients who are in some way insured differs from caring for the uninsured This applies not only to those with trouble with their backs but also to those with hernias, fractures of bones, tears of the knee cartilage, concussion of brain, etc The principal difference between the maured and the uninsured patient is that the latter patient is suffering from two or more ail ments medical legal, and, if you will, psychologic The only possible explanation of differing results is that either the insured patient is treated differ ently by the physician and by the industry maning them or that he reacts differently to treatment.

Many, and I think, most conscientious phy sicrans treat all groups of patients as nearly alike as possible. Almost none undertreat the insured patient. A few overtreat the insured patient with too many office calls, too much physiotherapy or medication that is of little or no value. A lew physicians have a penchant for bolstering their own ego by telling their patients both insured and uninsured how very serious their trouble is or how very difficult the operation was

to correct their trouble By doing so they seek Presented at the 141st Annual Meeting of the Medical

to enhance their own stature they may overimpress the patient with the nature or senousness of his ailment A few other physicians are seeking a chance to "get even' with some particular company for real or supposed injustices and do not hesitate to advise patients directly or indirectly to act differently than they would otherwise Another small group of physicians treat their insured pa tients more according to the dictates of some 'home office' physician or adjuster than according to the ments of the case and their own judgment The object of this is the continued good will and financial return from some com pany Another group-fortunately small-sim ply do not know the elemental facts of the pathology or physiology involved in back strain or injury have little idea of accepted methods of treatment, and do not have the ability to criticize and correct their own work and results

The mental attitude of the physician treating a patient with back pain and root pain as well as any other ailment is an important matter and one generally overlooked. There seems to be in the world only a small group of doctors who look with pleasure and eagerness and interest on the problem of unraveling the nature of a back complaint. By far, the majority look upon "backs' as an added cross to bear and assume a discouraged defeatist attitude which is all too soon reflected in their patients my own experience, I have had far better ex perience with patients who have been under the care of a general practitioner than the physician who has "tried everything and who has given the patient the impression that nothing done is of much use

We as physicians, try to talk too much pa thology to the patient. About all the average patient wants to know or needs to know is Can it be fixed and how well? The author does not mean to imply that one should ever do other than hew strictly to the line in his advice to pa tients, but does mean to imply that the best of any situation rather than the worst is to be emphasized There is adoquate room for an infectious, optimistic hopeful, yet truthful attitude toward the future of the patient with a "back,' whether he is insured or not

Society of the State of New York Buffalo Section on Neu-rology and Psychiatry May 9 1947

In addition to a medical ailment, the insured patient has the legal one mentioned, making for a real "complication of diseases" Many patients cannot decide for themselves which is the greater and readily devote their attention to the Both must be treated and cured if the patient is to obtain the desired result. It is of no value to cure a patient surgically and have him devote the rest of his life or an unusually long time to "getting justice" The reverse is Just as there are a few physicians who overtreat the patient, who are vindictive, selfish, ignorant, suffering from an inflated ego, so are there also a few members of the legal They undoubtedly account for a profession certain percentage of the failures under con-The physician who believes that sideration his word carries more weight on medical matters with the insured patient than does a union leader or an attorney is very often wrong. The umon leader who tells the man with the hernin how long he is supposed to be incapacitated does not hesitate to tell the man with a "back" what to do about return to employment

As part and parcel of the treatment of the patient's legal ailment comes the compensation A referee who will not accept court referee good medical or legal opinion that an illness is at an end and close a case can ruin any amount of treatment, however expertly given There is much to be said in favor of a nonpolitical "medical board" to decide the merits of controverted cases for a referee Argument in court between physicians or attorneys over a patient's condition or percentage of disability is most conducive to the development of a mental attitude that no medical treatment can cure, regardless of the actual pathologic condition Not all referees seem aware that few, if any, patients with any senous trouble ever return to former duties without some symptoms for a time Particularly is this true when an operation has been performed on a weight-bearing structure By law, the word of one physician is as good as any other in compensation court. It is incumbent upon the referee to know the relative ments of physicians and to seek and take their advice

Not by any means to be overlooked or forgotten in this discussion is the insurance adjuster and the company foreman or employment manager. Just as the first contact a hospital patient may have is with a medical student or first-year house officer, so the first contact an insured patient may have after the injury\_may be with an adjuster or a plant foreman or the first aid nurse. Such a contact may have farreaching influence, favorable or otherwise. Most adjusters reflect the attitude of their companies who have found that the more correct the medi-

cal information and treatment the less expensive in the long run is the care of the insured Therefore, they are eager to secure this Certain adjusters are in a difficult position in that they are not always their own agent but are under pressure from a "home office," or their company, to close a case as inexpensively as possible To do this, they not infrequently offer a patient a "lump sum" to close his case before rehable medical evidence is at hand Particularly is this true where the complaint is referable to a back or head injury. In order to convince a patient that a lump sum settlement is desirable, it is usually necessary to convince the man that his injuries do not amount to much people with back trouble believe this this, he must convince the man that medical treatment will be hazardous or meffectual or both No one would think of telling the average patient with a herma that he should not have it repaired because he might have a recurrence, might develop a hydrocele, might have a testicle swell up and then wither away leaving him "half a man," might have pain at an operative site, might have a numb area of skin below his incision, etc. However, all too frequently in my experience, adjusters or an employer have told patients solemnly that they might better take a lump sum settlement for a back injury producing a ruptured disk because the operation in question is "on the spine," "near the spinal cord" that no one can assure them that they won't have just as much trouble or more afterwards, that they may have a numb leg or a weak leg, that they may have to "be in a plaster cast," that they may be left with a stiff back, weak knees, or bad arches afterwards

When a patient cannot be "sold" on a lump sum settlement he is then turned over to a surgeon-usually after being away from work for months—and after the patient has "got a lawyer" The surgeon is silently dared to try to get him back to work If he fails, even partly, another entry in the "I told you so" column is It is the author's present practice to refuse to operate upon any insured patients who come in "as a last resort" after being told directly or indirectly by physicians and adjusters that there just is nothing else to try and not much use of trying that The insurance adjuster is further bedeviled by his home office, in some instances at least, to check constantly on "the medical progress of the case" It is not uncommon for a home office to want to see the x-ray films especially where pantopaque or other contrast media are used for study of the subarachnoid bed before any consent for further medical treatment Such interest is understandable at is given times and justified where the doctor is not known

to them, since they are paying for the treatment and eventually responsible for it The consultation with home office officials seldom takes less than two weeks' time, and more often, two nonths. Meanwhile the patient is usually sent home from the hospital, often quite a distance, and subjected to a good deal of discomfort in so doing. Some explanation for being sent home inecessary and only one reason can be given the patient. All this is most conducive to aggrava tion of his legal ailment. The fact seems to be lost might of that the spot wray films do not tell all of the story or present all of the cyrdence in any back complaint. The fluorescopy of the spine is of as much or more, value than the spot film in my opinion It would be far more per tment to the company involved to know and brep a record of the following facts (a) Did the operating surgeon see the fluoroscopy? (b) Who actually made the decision or the x ray interpretation regarding the presence of a pathological condition? Where contrast media is used the author seldom operates on a patient without linv ing personally seen it fluoroscoped

It is the rare patient who after x-ray or fluor ecopy of a spine and the taking of spot films does not justifiably ask what was the result of the examination and what is to be done surgeon who feels he must tell the patient that he cannot say until the films have been sent to the home office had better be doing some other type of work In our clinic, the decision is made at once and the patient told of this If the home office wishes to see the films they should be sent off by air mail and an opinion wired back within forty-eight hours Longer delay is mexcusable and a very definite detriment to the rehabilita tion of the patient. While no surgeon wants to be arbitrary, the final decision as to operation or other treatment must be his, for he is the one who has seen the patient, placed a value on his complaints, seen the x rays and fluoroscopy and the one who must answer to the patient and his family doctor for the result obtained A series of poor judgments or poor operative procedures will overtake any surgeon before he has gone very far If he does not agree with the "home office , be should go ahead according to the dictates of his own judgment and be willing to rise or fall by the outcome of his judgment

Nothing is more disastrous in the treatment of a patient with a low back complaint than to have him convinced that he is being treated as "a bill of goods' Particularly is this true where the person is having constant discomfort or pain and where treatment is withheld because of wrangling over authorization for medical treatment.

There is great need for the study of several

hundred records of patients who are listed by insurance companies as poor results. An adjuster for the Rochester office of the State Insurance Fund has stated that they have some seventy five such records. These should be studied by a committee made up of an orthopedic surgeon a neurologic surgeon a psychiatrist, and a psychologist in an effort to find properly the reason for the poor result if such exists.

Not to be forgotten by any means, is the patient who deliberately decides to use the ill ness as a club to obtain an end A woman pa tient recently left the hospital after the removal of a herniated intervertebral disk. She was free of complaints She abruptly reassumed all of her former complaints upon learning of her husband's extramantal activities while she was She has succeeded in keeping him home to wash dishes, make beds and do other housework after working hours. The insurance carrier lists her treatment as a failure. The physician does not. The referee in court refuses to accept advice and close the case. The patient undoubtedly will continue as an invalid as long as this situation exists.

The patient who is convinced that he is being forced to come for treatment by a doctor selected by an insurance company or by an industry should be disillusioned of this at once If he cannot, he should be discharged. Lafe is too short for the pursuit of policies of appearament with any type of patient—insured or uninsured—or in caring for any patient who does not wish to be treated

Very few physicians have looked upon the ruptured nucleus pulposus in the same light as they would a fractured tibia or femur or a dislocated hip or injury to any weight-bearing structure. There has been all too much of an ary dismissal of the problem as 'just a little piece of cartilage out of place.' Actually the operative site is one of a good deal of stress and strain and the operative treatment for the relief of root compression at times may require a fairly wide dissection of muscle attachments which are normally called upon for bodily support. I believe that the sooner this lesson is treated with the accuracy promptness dispatch and rationale accorded to a major weight-bearing structure the better will be the percentage of rehabilitations

The author does not mean to imply that every case of ruptured nucleus or other root compressive lesion should be operated upon The majority of minor ruptures of the nucleus pulposus will cease having symptoms if treated conservatively. What the percentage of total ruptures of the nucleus pulposus is in the world at large no one knows. I would estimate that

10 to 20 per cent of known ruptures should come to operation at some time There are certain cases of actual disk ruptures that for physical or psychologic reasons might better be left alone Among these are the uneducated, heavy laborer, 50 to 65 years old, who can do lighter work with-The same is true of the patient out discomfort who has had his symptoms for a long time, from two to three years, and who seems to be nearly over his trouble, having had his nerve root amputated physiologically or anatomically The person who loses little time from work is a very doubtful candidate for surgical treatment. The chronic alcoholic in his mid or latter years who has evidence of peripheral neuritis is a subject for very careful consideration To be looked over very, very critically is the person who is dominated by another to a large extent male who complains of a dull ache in his only to have his domineering spouse chime in "No, Herbert, you do not You have it in , and what's more, it doesn't ache, it pains you something terrible," may well be a poor candidate for any surgical treatment Others to be considered carefully are the women who have a record of having to go to bed for a week every month or who give evidence of not standing pain well The man who hopes to pay off the mortgage on the house and paper the upstairs on the proceeds of his insurance is a very doubtful candidate for surgical treatment The political figure or the city hall hanger-on who feels he is a cut above the average and who "is going to have a private room and they are going to pay for it" is another candidate to look over very If he cannot be convinced that he should be treated just like everyone else and on the basis of his trouble alone, he might as well be left alone He will be no greater burden on industry or society without a scar on his back than with, and probably less The patient who has had one unsuccessful operation is a doubly poor risk for another try, no matter what the findings may be

The lower in the scale of intelligence that a patient is, the fewer are the procedures that can be carried out on a trial and error basis less the patient's intelligence, the more prompt must be the settlement of his medical and legal troubles if he is to be rehabilitated to the fullest extent possible The longer the delay between the onset of an illness, the greater is the chance of the patient considering himself seriously ill both medically and legally The more procedures that are carned out that fail, the greater is the patient's justified distrust of any form of treatment The more the patient is convinced of the validity of his legal ailment the less are the chances of being rehabilitated by any medical procedure

There is one other group of patients who present a problem to the insurance carrier as well as the doctor, and who often finally are listed as having "poor" results This group is made up of workmen who have multiple injuries and who, perforce of age, education, disabilities, etc., cannot hope for much except for comfort and relief of pain from spinal root compression ample is that of a 55-year-old laborer who suffered a dislocated right hip, a fracture of both bones of the left lower leg, and a ruptured nucleus The last lesion was eventually the source of his greatest disability because of pain Although comfortable following operation for the disk lesion, he is no nearer doing his original hard work now than before removal of his ruptured nucleus pulposus He is able to do "gate work." He was entitled to comfort regardless of his ability to return to work The particular company in question does not agree with this However, of all companies dealt with, they are in the small minority

The company foreman or the employer or the company agent who refuses to re-employ a patient with a back complaint or one who has had an operation on his back can sabotage any amount of medical treatment. There is great need of careful sympathetic handling of the person returning to work, no matter what the illness has been. A few days or weeks assigned to light work or to shorter hours usually will suffice in rehabilitating most patients with back complaints The army sergeant or the foreman who "doesn't want a bunch of cripples in my outfit" and who proceeds to get rid of them in one way or another is doing a great disservice to all concerned

All of these abstract considerations may sound of small moment when real pathology can be demonstrated in a patient However, 1 firmly believe that the accurate evaluation of the patient's mental attitude and moral fiber is the most important single feature of the successful medical care and rehabilitation of the insured patient, particularly when the injury is to the In order to try to evaluate this, the surgeon must spend ample time on it I do not think that a patient can be evaluated properly much under a week's time for ample observation and thought During that period every reasonable effort should be made to see how he reacts to various situations and to adversity of the devices commonly used in doubtful cases withholding of permission to smoke for a couple of days by keeping him in bed and in a no-smoking zone, asking him to use the bed pan

instead of getting up to go to the toilet, asking him to walk varying distances outside the hospital or climb stairs. Noting his responses to such procedures as lumbar puncture or pantomore studies is also of value Notes on hours of seep the amount and kind of a medication or placebos necessary to keep him comfortable are valuable. The observation of the patient during early morning or evening hours or when playing eards or other games is of value in deciding how much pain a person really has. The patient who tells you in all succenty that he is not at all mirreded in the money involved but only in getting his health back has succeeded in deceiv mg himself in at least one sphere and very likely in others as well The amount of compensation being received compared with his usual emings is reldom a guide to a man's engerness to return to work in spite of what he may say

Patients also may be evaluated by allowing them to talk with others having similar troubles As a matter of fact this seldom can be prevented. In most hospitals, where neurosurgery is done there are seldom less than half a dozen postoperative "backs." New admissions seem to seek them out with uncanny and unerring cor "Follow-up" men patients almost inranably find their way back to the ward to say "bello" to nurses and orderies Women patients for some reason rarely revisit their old ward. New patients seldom nuss a chance to quir them on their progress and this is encour aged. If results cannot speak for themselves, nothing can After new patients talk with those in the postoperative state they are asked a few simple questions "Are you as badly off A or B? What do you want to do about this trouble? Do you want it done here or would you rather go somewhere else? Have you any thing you want to talk about? Do you know how long you may be in bed? Do you know when you should be able to go back to work? Are you having this operation because you want It or because someone else wants you to have 119"

Unless the patient's responses are pretty

straightforward and prompt I do not want him and will not have him on my list of postoperative cases. In the long run, they will be just as well off without operations and industry will be as well off to sottle with them as best they can

#### Summary

The successful treatment of the patient with an injury or a complaint referable to the back requires careful consideration of a number of factors, many of which are of an intangible na ture. The physician is, and should be the one held responsible for the outcome of any case even though there are many factors well outside his direct control. For that reason every patient with a complaint of back pain should be studied as thoroughly for the intangible factors in his illness as for the purely organic ones.

Among these intangible factors are

1 The mental attitude of the physicians who have treated the patient toward back injuries and complaints in general

2 The mental attitude of the attorney who

may be representing a patient

3 The mental attitude of the compensation court referce, or the armed forces disposition board or the judge in court toward continuing or closing a case on good medical advice

4 The attitude of the insurance adjuster and his company toward the patient

5 The attitude of the foreman or the com

pany
6 The attitude of the labor leader and his advice regarding the treatment or return to work

7 The attitude of the patient's relatives

toward his illness

8 The attitude of the patient toward his difficulties, both medical and legal, economic,

and psychologic

By careful attention to these intangible details, as well as the purely organic factors in disease or injury of the back one can expect as good or better final results as can be obtained in the treatment of any malady or injury of other weight-bearing structures.

41t ANNUAL CHRISTMAS SEAL SALE

Beginning on Novomber 24 and ending on New Year's Day the 41st Annual Christmas Seal Sale is being conducted in New York State with a goal of \$1,150 000

In charge, outside of New York City is the New York State Committee on Tuberculosis and Public Realth of the State Charities Aid Association through its 62 affiliated county and city tuber culous and public health associations

A large portion of Christmas Scal funds is devoted to promoting cheek x-ray surveys for the earlier discovery of the unknown cases of tuberculesis and to public health education in the all-out effort to rid New York State of tuberculesis by 1965. Proceeds are shared as follows 83 per cent for the programs of 62 county and city tuberculosis associations in the upstate area. 12 per cent for the state-wide program and 5 per cent for national work.

# THE IMPORTANCE OF EARLY DIAGNOSIS IN THE SURGICAL TREATMENT OF CARCINOMA OF THE LUNG

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IN THE past the hazards that attended resection of the lung for carcinoma were so formidable that physicians were willing to have their patients live a few months and die later of the cancer rather than risk an immediate death following operation

With the improvement of surgical technic, the simple resection of a lung has become a well-standardized procedure so that the mortality and morbidity following simple pneumonectomy is now relatively low. As experience in this field has increased, more advanced carcinoma cases have been successfully resected and more radical operation than the simple total pneumonectomy has been employed.

Radical pneumonectomy is now employed for carcinoma of the lung which has extended into the mediastinum This operation includes removal of lymph-bearing tissue in the mediastinum, in addition to resection of the lung the left side, the lymph nodes below the aortic arch, and behind the trachea, the lateral tracheal nodes, the cannal node, and the intertracheobronchial nodes are excised in addition to the hilar On the right side, division of the azygos vein with retraction anteriorly of the distal stump at its junction with the superior vena cava allows exposure beneath the cava and enables complete excision of lateral tracheal nodes up to the base of the neck, along with the carrial node and the intertracheobronchial nodes

Involvement of the mediastinum with carcinoma is now considered indication for removal of these nodes. Extension of the growth into the pulmonary artery, pulmonary veins, and pericardium makes removal more hazardous but is not considered cause for inoperability as has been advocated in the past.

With the extension of the carcinoma into the mediastinum, the risk of surgical removal is obviously greater. Not only has the disease advanced so that the patient is in worse condition, but the amount of surgery that he must withstand is correspondingly larger. In an extremely debilitated patient, the operation may be staged so as not to subject him to all the surgery at one time. He must then undergo two anesthesias, however, and run the risk of two operative procedures, so that the one-stage operation is far preferable. The two- or even three-stage procedure

is justified in extremely poor risk patients

The perfecting of the operation of radical pneu monectomy is the surgeon's answer to the medical practitioner who has not made an early enough diagnosis of carcinoma for the surgeon to operate at a time when simple pneumonectomy is pos-Appreciation of the early changes of carcinoma of the lung will enable the physician to make an earlier diagnosis This will bring the patient to exploration earlier and will allow the surgeon to perform simple rather than radical pneumonectomy Thus, early diagnosis will lower the mortality and morbidity of the surgi cal procedure and will increase the patient's chance of five-year survival, because his disease is removed before metastasis has occurred

Review of the causes for failure of early diagnosis resolves itself into an inability to interpret the early x-ray changes of lung carcinoma and poor evaluation of the importance of negative Approximately one bronchoscopic examination fourth of cases of carcinoma coming to operation have a completely negative bronchoscopic examination, and in this group the incidence of resectability is appreciably higher than in those with positive biopsy, which emphasizes the significance of negative bronchoscopy some malignancies of the lung are rapid growing and others are slow growing is well known, but for the rate of growth to be appreciated by \-ri> may mean that the disease has become incurable under the eyes of the physician Similarly, decision to wait for symptoms to develop entails a delay that may allow a resectable growth to become inoperable If more cases are to be resected early in the disease, early exploration on suggestive \-ray changes is imperative without waiting for positive bronchoscopic evidence or the usual symptoms associated with the disease

The frequency with which physicians unknowingly encounter carcinoma of the lung, either on
routine examination or in the course of treatment
for some other condition, makes it imperative
that they familiarize themselves with the x-ray
changes that suggest the disease—Only then will
such cases be directed into the hands of surgeons,
who, by operating early, will insure the best
change of survival

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### PAGET'S DISEASE AND THE CENTRAL NERVOUS SYSTEM

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(From the Jewish Sanitarium and Hospital for Chronic Diseases)

THE-not infrequent occurrence of neurologic syndromes in patients displaying Paget states of the bone has been repeatedly described, but the beas for the development of such symptoms has not been given adequate emphasis

Gles de Tourette¹ and Marinesco² in 1894 and 1890 were the first to report changes in the spinal end in a sufferer from this disease. In the first trenty-five years of this century numerous cases with neurologic complications were described but predically all consisted of well-defined conditions of the nervous system occurring coincidentally with and apart from the bone disturbances Typical diseases such as tabes dorsalis and magomyelia were presented The common association of the disease with the metastatic lesons of carcinoma was commented upon by Wolf who described a case with an esteoplastic utradural bone tumor compressing the right cerebellar hemisphere.\* Pond' reported a case of pituitary tumor with abscess of the sphenoid ams Garvey a case of tumor of the nasoplarynx, and Birds reported sarcomas in 11 of 64 cases of the disease

The first real evidence of disturbance of the spinal cord attributable to the disease itself and resulting from the effects of alterations in the bony envelope of the nervous system was desenbed by Wyllie in 1923 7 He reported spinal cord compression produced by vertebral collapse in the course of Paget's disease Relatively few additional case reports have appeared since then, despite recognition of the occurrence of spinal cord syndromes of this nature Other disturbances such as psychosis, convulsions, deafness visual difficulties due to optic atrophy and brain tumor syndromes have been related to the disease Vamerous authors including Stauder Glassher Greeg 10 Gross 11 Grunthal 12 John and Masser, 13 have shown that Paget s disease of the bone may lead to neurologic symptoms Moynam reported a case with arteriosclerotic symptoms and compression of the brain 14 Marie s case was diagnosed as a paranoid with epilepsy dia betes, and "erosion' of the sella turcien 18 John and Strasser reported 2 cases with intracranial pressure and neurologic symptoms.13 Nonne stated that epileptiform seizures impairment of eight and bearing from nerve compression dis-

Presented at the Annual Meeting of the Medical Society of the State of New York Buffalo, Section on Neurology and Psychiatry May 9 194

turbances in taste trigenimal paresthesias and pain facial paralysis spinal paralysis and neural gic pains of the extremities have all been en countered.<sup>14</sup>

Homen (1901) in correlating the neurological abnormalities and postmortem findings demonstrated the local pressure effects upon the medulia oblongata of the odontoid process, resulting from softening and deformity of the base of the skull produced by decalcification. Schüller (1911) desembed the effects of bony deformities upon the central nervous system. In 1939 Chamberlain reported 4 cases of busilar impression with because neurologic anomalies. In 1934 Wyers laid described such anomalies in a case of busilar impression resulting from the deformities of Paget's disease.

This presentation is concerned with a report of 5 cases of disease of the central nervous system all of which had been diagnosed as clinical entities which were not previously considered as due to the effects of Paget's disease. However upon reconsideration it was noted that each case presented atypical features that rendered the diagnosis of a classic disturbance improbable and therefore the search for an explanation for the unusual features led to the opinion that the effects of Paget's disease had caused the alterations of the central nervous system which produced the symptoms

#### Case Reports

Case 1 -The patient a 52-year-old woman, had suffered two attacks of come that produced transient neurologic signs consisting of weakness of the lower extremities and a left Babinski. Her fixed symptomatology consisted of bilateral deafness and poor vision resulting from optic atrophy She entered the Jewish Samtarium and Hospital for Chronic Diseases in 1939 complaining of inability to walk following a fracture of the femur which occurred during convalencence from pneumonia. Bony deformities typical of Paget's disease with multiple fractures of the extremities were noted on x ray The typical appearance due to skeletal and skull doformities had developed from 1929 to the time of her admission in 1939 Eight months following her admission in August 1939 she developed a sudden coma which lasted fifteen minutes following which she was confused and presented a right supra nuclear facial paralysis. Although all extremities moved the lowers were externally rotated and there was a left Babinski sign. All the signs sub-aded

Five months later there was a within three weeks repetition of transient coma with the same neurologic findings which again subsided in two weeks after there was a change in personality consisting of stubbornness, uncooperativeness, and suicidal be-She subsequently developed several episodes of cardiac decompensation in 1942 and 1943 and expired in August, 1943, from the latter laboratory findings were an alkaline phosphatase of 24 1 Bodansky units in 1939 and 25 92 Bodansky units in 1943 X-rays revealed involvement of all the bones of the extremities and showed that the skull was completely sclerosed with a flattened base There was calcification of the vascular channels, such as abdominal aorta, pelvic vessels, and of the muscles, tendons, and subcutaneous tissues patient had lost 10 inches in height from 1929 to 1943 Her hat size had increased 61/2 inches, from  $22^{1}/_{2}$  to 29 inches Difficulty in hearing began in On admission she had presented bilateral deafness, the skeletal deformities, and poor vision m the left eye so that she could not count fingers Vision was good in the right eye Thus, this patient with advanced Paget's disease entered the hospital with neurologic signs consisting of bilateral deafness and poor vision, having suffered two attacks of coma of fifteen minutes' duration, followed by weakness of her lower extremities and a left Babinski recovered from these sequelae to her coma in two or three neeks She presented an acquired platy basia and diffuse arteriosclerosis which accounted for the acute neurologic disturbances as well as narrowing of the cranial nerve foraminae which accounted for her deafness and visual disturbances

Case 2 -The patient was a man who came under consideration when he developed, in addition to certain fixed neurologic signs, transient ocular muscle palsies that were assumed to be due to intracranial alterations resulting from a pituitary tumor The changes seen in the sella turcica were believed to be due to a neoplasm until further consideration and study indicated that these alterations were consistent with the bony deformities of the skull resulting from Paget's disease This 56-year-old-man was admitted to the hospital in June, 1946, complanning of pain on the right side of the head and body and in the right arm and leg There was bilateral deafness, more marked on the right side, and dizziness when sitting up for ten minutes or more The onset of his disturbances had occurred at the age of 40 when he developed pains in the chest radiating up the neck, around the scapulac, and down both arms He was dyspneic, suffered from gaseous distress, and at this time was confined to bed for three months, he received morphine for rehef and was told that he suffered from heart disease or gallbladder trouble At the age of 47, he noted that he was becoming hard of hearing, the deafness being apparent in the right ear where it was accompamed by tinnitus At the age of 49 he suffered from attacks of vertigo, tinnitus, and weakness, so that he fell one day when getting out of bed had been unable to walk since Thereafter weakness extended to the right arm and fingers He was hospitalized for three weeks and was discharged with

the diagnosis of Paget's disease, Mémère's syndrome, and fracture of the third lumbar vertebra With the onset of vertigo he developed supra-orbital headaches which occurred with change of position In 1940, at the age of 50, he noticed that his head was becoming larger Upon hospitalization in 1942 there was noted a spastic weakness of the right lower extremity and weakness of the right upper ex tremity, increased tendon reflexes in the right upper extremity, and increased and equal reflexes in the lowers where bilateral ankle clonus was present Bilateral papilledema, a left central facial weakness bilateral nerve deafness, a fine tremor of the tongue and concentric diminution in the visual fields were X-rays revealed evidence of Paget's reported disease with compression fracture of the third lumbar vertebra, osteoarthritis of the spine, and osteoporosis of the posterior half of the left side of the The alkaline phosphatase levels were 307 and 32 1 Bodansky units, and the acid phosphatase was 39 Gutman units He complained of con tinual backache and headache throughout this period of hospitalization

When hospitalized in June, 1946, his complaints were unchanged Bilateral deafness, more marked on the right, weakness of the right upper and lower extremities, bilaterally hyperactive reflexes with bilateral ankle clonus, a positive left Babinski with confirmatory signs and tremors of the upper extremities were noted Ocular convergence and upward gaze were limited. The retinal arteres were sclerotic and the visual fields were contracted.

He complained of double vision one month later At this time the right eye was deviated outward The right with loss of motility in all directions pupil was larger than the left, both pupils reacting The optic nerves were pale and sluggishly to light the disk margins were blurred There was bilateral nerve deafness more marked on the right right lower extremity was spastic, the knee and ankle jerks were bilaterally hyperactive, with ankle clonus and Rossolimo signs on the right and a Babinshi on Only the left lower abdominal reflex was the left sluggishly present A hyperalgesic zone was noted at the sixth dorsal level on the left and slightly higher on the right

In September the right eve had regained most of its motility, the optic nerve heads were still blurred and pale but the visual fields appeared grossly por-By October the ocular paralysis had commal There was weakness of the nght pletely subsided lower extremity and slight weakness in the right Rossolimo's sign was obtained on upper extremity the right Babinshi's sign was not elicited. alkalme phosphatase was 958 (June, 1946), 163 (December, 1946), 23 4 (January, 1947) Bodansky Spinal tap revealed an initial pressure of 152 There was no evidence of submm of water arachnoid block Fluid analysis was within normal X-rays revealed an old fracture of the third lumbar vertebra and possibly of the fourth with anterior dislocation of the lower lumbar vertebra General decalcification of the spine and pelvis was The skull was enlarged, cotton woolly described m appearance, with an enlarged flattened sells

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turce and widening of the angle between the anterior and middle forsze of the skull and flattening of the tase. The orbits were distorted as a result of aperimposed calcifications and decreased density. The optic canals were indistinct and there was an an of calcification in the region of the left optic framen. A pneumo-encephalogram taken January 3 1917 revealed a marked increase in aubarachnoid ar Cerebral neoplasm was thus climinated as a case of the transient ocular symptoms.

Can 3—This patient was a 55-year-old woman thi tripical head and skeletal deformities of Paget s fease. She had suddenly developed a left hornipiesa and loss of speech in March of 1945 Four months later on admission to the hospital she promuted bilateral deafness, and pale blurred optic disk margins together with a left hemiplegia and sphais.

The alkaline phosphatase was 19 6 13 7, and 13.5 Bodansky units on several occasions in Bis. Y-rays of the skull revealed a heavy flattened wh turcica, involvement of the orbits and sphematical ridges elliptical distortion of the foramen agrams and a woolly appearance of the vault with temendous thickening of the skull tables. The attretters disks from the aixth to tenth dorsal tertebra was fractured. The abdominal north was calcifed. One year later she presented bilateral pyramidal findings, consisting of Babinski Rossolimo and Chaddock signs

Although this woman developed an acute homi pera, she presented multiple signs of diffuse involvment of the central nervous system due to the stall and spinal deformations as well as the vascular things associated with Paget a disease.

Case 4.—A 45-year-old man entered the hospital is 1931. He complained of a sudden onset of slutting of the right upper and right lower extremities in 1924 at the age of 38 a few weeks after an automobile acculent. The tremors lad increased in in leasity to the time of admission. The right leg was dragged in walking the right upper and lower extremities were spastic, the arm being hyperprotected and adducted. There were rhythmic tremors of wide amplitude (Flügol type) in the right upper extremity and of lesser amplitude in the right lower extremity and of lesser amplitude in the right lower extremity and of lesser amplitude in the right lower extremity and of lesser amplitude in the right lower extremity. A right central facial palsy bilateral labinations, champing movements of the javs tremor of the head and slurred mumbling speech were noted.

Thus patient presented features of Parkinsonism thesity comusting of rhythmic tremors of the right entermities immobility of the face and cycballs dissipated eye wink, anteroposterior tremors of the bead, champing jaw movements cogwheel phenomena in the involved extremities and difficulty in upward gaze and convergence. There was evidence of pyramidal disease consisting of bilateral Babinski signs and hyperactivo tendon reflexes. Cerebellar pathway disease was manifested by bilateral finger to none and heel to knee atxia. There was bilateral point arrophy Y ray revealed advanced Paget's disease of the skull pelvis and hips, and spine The skull revealed an irregular dense deposit throughout

its tables most marked in the frontal region with flattoning of the base and calcification of sphenoidal ridges and other foramina. Calcified blood versels were observed. The alkaline phosphatase was 15 Bodansky units.

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The diagnosis of multiple sclerosis had been made in 1925. Unistory of remission and exacerbation of the disease was not obtained. The diagnosis of epidemic encephalitis was made in 1920.

The sudden onset at the age of 38 of neurologic signs indicative of basal ganghon, cerebellar pyramidal tract and optic nervo disturbances in a patient in whom a diagnosis of acute encephalitis and multiple selerosis had been made many year previously could be attributed only to the effects of Paget's disease upon the nervous system. Vascular alterations and bony distortion are considered the basis for these alterations

Case 5 -A 58-year-old man was admitted to the hospital in July 1946. At the age of 45 he had developed sudden weakness of the left upper extremity and both lower extremities without loss of conecrousness. A few months later he experienced sparms of both lower extremities. A diagnosis of multiple sclerosis had been made in 1937 had been no evidence of remissions, exacerbations, or ocular bladder or reusory disturbances. One year later he presented spastic paralysis of both lower extremities flaceid paralysis of the left upper extremity loss of vibratory perception in both legs and feet with diminished perception of painful and thermal stimuli to the level of the iliac crests tendon reflexes were not obtained in the right upper extremity were sluggish in the left upper extremity and were active in the lower extremities where bilateral ankle clonus, bilateral Babinski, and Hoff man signs were obtained. The abdominal reflexes were not present. Upon hospitalization in 1946, he presented bilateral optic nerve pallor flaccid weak ness of all the musculature of the left upper ex tremity with atrophy of the intrinsic muscles of the hand and unobtainable reflexes The abdominal reflexes were not obtained. The lower extremities were spastic and presented adductor spasm and hyperreflexia, ankle clonus and bilateral Babinski signs. Vibratory perception was lost in both lower extremities, being diminished to the level of the iliac crests The patient therefore presented Paget's disease

of the bone and a syndrome recembling amyotrophic lateral sclerosis Spinnl tap revealed no evidence of subarachnoid block The alkaline phosphatase was 8.8 Bodansky units Lipoid was noted within the lumbosacral subarachnoid space. There were increased areas of density in the lumbar spine the fourth lumbar vertebra revealing marked deformity with lipping, narrowing of the intervertebral space between the fourth and fifth lumbar vertebrae increased density alternating with decreased density throughout the pelvis deformity of the tibiac with changes similar to those of the pelvis, increased density of the skull consistent with Paget a disease calcification of the pelvic vessels and advance hypertrophic arthritis in the entire cervical spine. This patient likewise presented an atypical neurologic syndrome associated with Paget's disease The vascular and bony alterations of the latter are considered the basis for the neural alterations

These 5 cases presented various types of symptomatology resulting from involvement of the nervous system Three cases were deaf, 4 revealed optic atrophy, 4, involvement of the brain, and 3, involvement of the spinal cord turbances may be attributed to alterations produced by the deformities of the skull, spine, cramal nerve foramina and calcified vessels which were present in every case None presented typical syndromes but the diagnoses of multiple sclerosis, acute encephalitis, amyotrophic lateral sclerosis, paralysis agitans, spinal cord tumor, brain tumor, and cerebral thrombosis had been made, the etiologic relationship of Paget's disease having been overlooked or disregarded

Levi, in 1897, showed that changes in the neryous system in this disease were often secondary to endartentis and penartentis of the small vessels of the spinal cord which resulted in poor blood supply to the cord, the bony disturbance and vascular changes being coincidental in the same patient 21 Emerson (quoted by Lewin 22) believed the cord changes are due to arteriosclerosis conception subsequently was verified by Hudelo and Heitz in 190123 and by Palmgren in 1927 24 Gielman stated that atheromatous changes in the vessels were found constantly in the disease 26 The common occurrence of vascular alterations in our cases would serve to support the contentions of these observers Schwarz and Reback stated that arteriosclerosis is very frequent and that some writers have suggested that the bony changes may be compensatory to altered blood supply to the bones by arteriosclerotic blood vessels 26

Gutman and Kasaback in their report of 116 cases ascribed the symptomatology to pressure of the bony envelope of the nervous system upon the cerebellum, spinal cord, and nerve roots <sup>27</sup> Gregg believed that long before the stage of gross deformity of the skeleton had occurred, symptoms of interference of function of the nerves crowded by proliferating bony structures may appear <sup>10</sup> The presence of deafness and optic atrophy in our cases bears out this contention

The frequency of the various types of symptomatology was reported by Gutman and Kasaback who stated that hearing impairment was the most common manifestation of cranial nerve involvement, reporting 26 cases with deafness in their series of 116 cases <sup>27</sup> Impairment of vision was not uncommon but optic atrophy was observed in only 4 cases. Clinical evidence for diagnosis was not present in two thirds of their cases and the diagnosis depended on \ray studies. Involvement of the base of the skull occurred in 7

cases and then only in the presence of advanced lesions of the vault — Four cases in our senes of a showed basilar alterations

The frequency of hearing difficulty may be attributed to the deformities of the base. Fowler reported 99 cases in which deafness was an initial symptom in 3 and a major symptom in 41 in stances <sup>73</sup> Lindsay believed that impairment of hearing does not occur except in patients with extensive disease of the skull, including the temporal bone <sup>29</sup>

In Gutman and Kasaback's series, x-ray evidence in the spine occurred in 26 cases in the dorsal, in 51 cases in the lumbar, and in 5 cases in the certical spine Turner stated that it is not the "advanced" cases that suffer from spinal cord compression. He described three types of spinal syndrome, namely, those due to compression, those due to vascular disease with sudden onset possibly secondary to compression, and those due to vertebral displacement producing hematomyelia. Three of our cases showed fracture deformities of the vertebral bodies, all showed extensive involvement of the spine and interspaces. Psychoses appeared in one case in this group

Paget, himself, noted with surprise that the mind remained unaffected even when the skull was un usually thickened Stauder stated that only rare reports are found concerning psychic disturbances 8 Smith<sup>31</sup> reported 2 cases and Kaufman, 4 cases 32 Increased intracranial pressure has usually been accepted as the cause of psychic disturbances A study of the skull x-rays in advanced cases, however, reveals an actual increase in the brain case capacity The encephalogram in case number two with a pituitary tumor syn drome revealed dilatation of the subarachnoid spaces with air, suggestive of the presence of "cortical atrophy" Although this patient presented no psychotic symptoms, the typical skull enlargement with a relatively normal cerebral outline confirms the presence of an increase in the This patient like capacity of the skull cavity wise demonstrated an enlargement and flattening of the sella turcica which was altered in shape duc to flattening of the fossae of the skull cases have been described by Hurwitz<sup>33</sup> and Levi <sup>21</sup> Len's description in 1913 of conversion brought attention to the occurrence of acquired platybasia in Paget's disease 34 Lewin demonstrated three cases with shallow and elongated sellae such as occurred in our case 22 This deformity is brought about by sagging of the base of the skull around the foramen magnum which is supported by the spine, the weight of the cerebral hemispheres depressing the sphenoid and The upward slope of petrous temporal bones the anterior basal portion of the occipital bone and the dorsum sellae become reduced or lowered.

moducing a platy basic and in severe cases a conresolusie The anteroposterior and transverse skull diameters are increased and the vertual diameter is decreased. Torsion, stretching and saring of the brain stem resulting from these bony deformaties, therefore may produce eranial herve agas as well as signs referable to involvement of the pyramudal system

The etiology of Paget a disease of the hone does not establish the cause, but it has been suggested that it may be eaused by a central ners our system disturbance Lancercaux suggested such a nosstility and pointed out the relationship between bone dystrophy and nervous disease as an argu ment in its favor 25 Lewin believed that central arrous system disturbance may produce an al tered bone metabolism, the duetless glands being intermediary in its causation 22 Ivimov sur galed a trophic center for bone in the nervous 175km.34 Knagg37 and Kaufman32 formulated the concept of a toxic cause stating that arterial and bone changes were due to the same process home,16 dangreeing with Guillain 13 and other French authors who maintain that the disease is rephilitic in cause, looked with favor upon the assumption that it may have some connection with disordered parathyroid function chemical alteration found in the disease is an in crese in alkaline phosphatase in the blood (Kay 1020) \*\*

#### Summary

1. When neurologic symptoms occur in patients with Paget's disease of the bones the effects of the latter upon the nervous system must be considered as the causative factor

2. The alterations in the nervous system are the result of compression of nervous structures by the deformed bony envelope of the central neryous system and of the disturbances in nutrition caused by calcification of blood vessels of the brain and spanal cord

2 The diagnosis of neurologic syndromes in patients with Paget's discuse too frequently is dissociated etiologically from the latter

4. Five cases are reported in whom the alypical neurologic features of paralysis agitans,

amyotrophic lateral sclerosis, multiple sclerosis, brain tumor spinal cord tumor cerebral throm bosis acute encephalitis, and recurrent coma with transient involvement of the nervous system sug gested an atypical cause for their production

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# CANADIAN FEDERAL HEALTH SCHEME LOSES GROUND

According to Paul Martin Canada's Minister of ational Health and Welfare the Dominion health scheme is loung ground due to lack of interest

In 1916, the sovernment requested \$42,000 for the purpose of investigating health insurance. Only \$4,700 was apout on the study In 1947 only \$27 882 \$27 863 was requested. Fallure of the scheme is

attributed to the fact that the planners were unable to devise a plan satisfactory to the medical profession. There is every indication that Canadian doctors would rather work through voluntary plans and insurance programs than through a government department.-Canadian Insurance September 8 1947

# NARCODIAGNOSIS AND NARCOTHERAPY IN THE NEUROSES AND PSYCHOSES

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TOW far does the sodium amytal technic HOW far does the sound help in pyschiatric diagnoses? Blickwenn made the first claim, stating that in neuroses and functional psychoses he required less of the drug to set forth stimulating or narcotic effects than he did in the organic psychoses This claim is to some extent correct, but in the majority of cases we cannot confirm it Since 1930 much evidence has accumulated proving that sodium amytal can be used effectively in differentiating neuroses from psychoses Furthermore, it can be employed in order to gain a better understanding of the structure of a particular neurosis or psychosis In everyday psychiatric practice, it is quite a common experience to be confronted with this vexing problem anxiety neurosis or depression true manie attack or schizomanie reaction, or, most often, schizophrenia versus psychoneuicsis These conditions often await differentiation the same way, the differential diagnoses of manicdepressive psychosis or schizophrenia, and psychogenic or organic conditions often are greatly facilitated by sodium amytal About half of the patients interviewed following administration of amytal disclosed mental contents which were not revealed before, many patients disclosed hallucinations and delusions which were not sus-This effect is especially apparent in prtients in whom schizophrenia is suspected but in whom no clinical evidence is present to establish the diagnosis Misapprehension is to be allayed at this point concerning drug-produced hallucinations or delusions Doses of 3 to 7 half-grains of sodium amytal do not produce imaginations of delusions in persons in whom a psychosis is not present, with the exception of some patients showing marked exhaustion, for example, those with war neuroses We never saw a drug dehrium in our patients Admission of hallucinations and delusions usually are related by the patient in a vein similar to that observed during a routine clinical interview Many patients, furthermore, are not amnesic after the sodium amytal interview and later on know what they disclosed during the interview and can be confronted with that evidence Sodium amytal does not influence the structure of the hallucinations and delusions Thus bringing into bold relief the morbid productions without

Presented at the 141st Annual Meeting of the Medical Society of the State of New York Buffalo, Section on Neurology and Psychiatry May 8, 1947

distorting them is a great advantage of amytal and pentothal over cocaine, alcohol, scopolamine, cannabis indica or mescaline, and many other Besides eliciting hallucinations and delusions, other mental mechanisms become more echolalia, bizarre obvious too Mannensms associations, and incoherence are also illuminated during the interview In addition, the patient is able to give an interpretation of his symptoms and sickness and, in general, is inclined to discuss his own interpretations. Functional amnesias. similarly as in hypnosis, are also revealed in any These observations are in no contra diction to the observation that many psychotics apparently become normal in speech, ideation, and behavior under amytal, and that it is posible to produce in them with the drug, a temporary lucid interval Usually, soon after injecting the drug, the patient is in a communica tive frame of mind The above-mentioned symptoms are displayed in about the first half of the interview As the first impact of the drug wears off and more is injected, slowly the morbid phenomenon indicating a release or lowering of certain coordinating or inlubiting functioning begins to disappear and a synthesis takes place, leading to the normalization of the patient This bifocal action is quite interesting (Seconal, even in small and not fully explained amounts intoxicates much more rapidly than amytal and sometimes shows this type of reaction more clearly) It is possible that, in a small amount, the drug acts as a cortical stimulant, but in higher doses, as a depressor If such is the case, in this respect it shows a similar action During ether narcosis at as alcohol or ether first excitatory and later cortical depressive Insulin. too, to manifestations are observed some extent acts similarly

Many patients before the interview are in a state of emotional tension, dominated by fear, and complaining about many somatic disturbances. In these cases, it is remarkable how quickly sodium amytal removes the emotional push between the symptoms, eliminates fear, and diminishes the perception of bodily sensations. The patient becomes more detached and is able to view some of his symptoms, like obsessions and phobias or some delusions, more objectively because the emotional impetus is reduced. Therefore, secondary manifestations

of the mental state are removed and the essential pamary disturbances are in clearer focus. The dynamics of the psychosis or neurosis usually become clearer, especially in the neurosis. An assessment of the most important points of the dynamics can be obtained faithy rapidly.

dynamics can be obtained fairly rapidly Narcotherapy in different forms, such as narcosuggestion, narcocatharms, and narco-analysis was extensively used in the treatment of war neuroses. It was proved to be of great value in dealing with functional amnesic states of all hinds, in influencing conversion symptoms in amoving auxieties, and in influencing certain psychosomatic conditions. A large number of patients suffering from the more superficial form of war neuroses responded well to this form of treatment In those patients, however, in whom a marked emotional instability was present before the appearance of the war neuroses, or in patients abs previously were suffering from a neurosis which was only activated or aggravated due to the war experience, thus treatment was less effective. In many of the superficial war neu roes, fatigue or exhaustion played an important role and the overstimulated nervous system needed sedation. In this form of treatment, edation and psychotherapy were linked together The drug facilitated the psychotherapy by rapully establishing a better contact The abreaction of incidents loaded with anxiety or other emotional elements was facilitated. This emotional discharge was made easy and relatively painless. The general emotional instability and especially the anxiety were relieved. The patients who were usually very tense and over wrought relaxed completely Another great advantage of this treatment was that the vegeta tive dysfunctions which are so often present in the war neuroses were diminished considerably and that the patient's oversensitivity to stimuli was markedly reduced. It was also obvious that many hysterical mechanisms were relieved More superficial ones showed a restoration of dissociation very quickly sometimes even before Pychotherapy was applied In others however Psychotherapy reinforced the action of the drug The drug produces in many individuals a form of hypnotic trance which facilitates the application of psychotherapy and at the same time by detaching the patient from the anxiety is able to reveal some of the underlying structure of the war neuroses The removal of inhibitions by the drug establishes a better rapport especially in shy individuals who are preoccupied with the ideas and experiences they seemed ashamed to men tion A great deal of time is saved by this method

of investigation and questioning

Even though we were aware of the fact that
the structure of the civilian neuroses is quite dif-

ferent from that seen in the war cases and especially that the element of fatigue and exhaustion is not often present in the ordinary neurosis many other mechanisms are quite common. For instance dissociations in hysteria and especially anxiety manifestations in the anxiety neuroses The vegetative manifestations of anxiety like palpitation of the heart, gastrointestinal disturbances and perspiration which are the tension accompaniments of the anxiety, often produce typical manifestations which are similar to those seen in the war neuroses. We believe that the same advantages which this treatment offered in the war cases will show in the civilian neuroses It is apparent that this form of therapy yields different results in the different forms of neuroses The best results are obtained in the anxiety neuroses and conversion hysteria cases of anxiety hysteria and in the obsessivecompulsive neuroses the response is much less satisfactory even though in these individuals a marked amelioration of symptoms can be achieved at least temporarily This method again demonstrates the fact that the more superficial neuroses are responding to brief psychotherapy in the same way that they are responding better to other forms of psychotherapy whereas the more ingrained and more deeply structural used psychoneuroses are much less influenced. In the anxiety neuroses and in the conversion hysterm, this treatment form accelerates the treatment and makes it available also to individuals who otherwise would not be able to afford psycho-The elimination of anxiety and the relief which patients receive due to the quieting of the vegetative manifestations make the treatment also effective in individuals whose intelli gence does not permit the application of psychoanalytic methods which require a rather good intelligence to understand psychodynamics. The marked suggestivity which is occurring in these patients during an amytal treatment enables us to combine a hypnotic technic with the more ex plorative one using both elements in psychotherapy the quick symptom elimination of hysterical or anxiety symptoms on one hand and the deeper exploratory treatment on the other hand It enables the physician similarly as in hypnosis, to use a covering and uncovering treatment simultaneously

It is important to mention that brief psychotherapy does not mean lay psychotherapy nor does it mean that now psychotherapy can be handled more quickly and effectively by persons who have very little acquaintanceship with psychiatry. We have the impression that some groups think that by injecting the drug and suggesting a few things to the patient psychotherapy is given. I believe some of the failures with this

technic can be attributed to the fact that persons not sufficiently acquainted with psychotherapy in general were unable to utilize its advantages It is obvious that a formal knowledge of psychotherapy is probably more important in doing short psychotherapy than in long, because the necessity of adjusting the therapy to the patient and of utilizing the material the patient produces in a short time is more complicated than if long-term psychotherapy is applied Horslev stresses the fact to avoid a stereotyped technic in this method of treatment which is still in an experimental stage A stereotyped technic tends to give stereotyped results He suggests, for instance, that light narcosis sometimes succeeds where deep narcosis is completely unsuccessful Suggestion succeeds where analysis does not and vice versa

In the following there are a few illustrative case histories

# Case Reports

Case 1 —A 26-year-old woman patient developed an anxiety state in June, 1944 She claimed that she became sick after donating blood, even though this was her third donation and on previous occasions she did not develop any symptoms complaints were pulpitation, dizziness, weakness, fear of death She had to give up her work patient stayed home for several months and as her leave of absence was approaching its expiration date and she did not want to lose her job, she was looking for treatment A trial of short psychotherapy was suggested Under sodium amy tal, the patient revealed that she actually became ill by serving as a nurse's aid in a mental hospital. She became upset seeing a patient hugging and kissing another patient She developed the idea that she would become insane too. She revealed a marked hostility toward her mother who dominated her, and an mability to adjust in male company very marked ambivalence toward the supervisor at her place of work.

The patient had eight interviews in which she elaborated on all the above-mentioned material. Anxiety diminished markedly, palpitation disappeared and she resumed work.

Case 2 —A 30-year-old man, rather reticent, was referred for treatment with the diagnosis of peptic ulcer which was verified by \ray He was treated for one year for angina pectoris His symptoms were palpitation of heart, fear at times, increased perspiration, feeling of dizziness When upset about something at home or at the office, he had pain in his stomach and heartburn He was convinced that he was suffering from heart disease and lived accordingly In several psychotherapeutic sessions with sodium amytal, the patient related the following Since childhood he has been suffering from anxieties which have become much more marked the last three years He is afraid something will happen to him, thinks of death, and is very superstitious He tries to buy his way of out his anxieties He says "If today I am not anxious or if nothing happens to me or my family, I will give some money for charity" He has quite a number of similar rituals which should prevent the occurrence of a catastrophe He is obsessed by thoughts con cerning his family, especially his mother, because his parents are growing old, he is preoccupied with every little sign of weakness in them. It is inconceivable to him that they could die He is very much attached to his family and moves practically only in his family cycle. In another session, he revealed that all the time he has to think of sexual things which obsess his mind and make him absent-minded. He is married, but he is not anxious about his wife or his child. He is only able to perform intercourse when he thinks of another woman other than his wife, he reyeals ideas that he would like to live with his mother in the same place where he lived as a small child and would be rather reheved giving up his marriage and his adult responsibilities. All this material was rather quickly obtained from the pa tient with many details which we have no time to describe The anxiety of the patient was relieved, and the marked tension, which prevailed before the He had no treatment, diminished considerably pain in his stomach, attended to his business with increased efficiency, and lost many of the phobia. and obsessional thoughts As the neurosis appeared to be rather deep-seated, a prolonged form of psichotherapy was suggested. The patient, however, was unable to do so and retained the improvement, which was obtained by short psychotherapy in about twenty sessions, for about nine months Even though it is not claimed that the neurosis was elimi nated in the patient, for the first time in many vears he received a very impressive symptomatic relief which enabled him to work and adjusted him fairly well. This example indicates that even in very deep-serted neuroses, where usually short psychotherapy is not sufficient, temporary results of fairly long duration can be achieved

Case 3—A 42-year-old woman patient, with a previous normal history, had been riding in a car when at a sudden stop she fell forward and struck her chest, sustaining a slight bruise There were no other organic findings

Soon after the accident, the patient complained about mability to move her leg An hysterical page ralysis of the right leg was found The patient asked for compensation for the injury, but did not pres her claim Psychotherapy with sodium amytal was started At the first session, the hysterical paralysis of the leg was removed In following sessions the patient disclosed that before she suffered the acci dent she was in a constant state of anxiety for about eight months She is obsessed by the idea of passage of time She constantly had to look in the mirror to see if she was growing old or not. The fear started about eight months ago when she had to pass a funeral procession She tried to figure out why we are born and why we have to die Later on, she had attacks of fear when she had to pass funeral parlors and beauty shops She was sleepless at night, and had to think in obsessive fashion about her past life The patient was married, and had entertained the idea of divorce for several years, but was afraid if the divorced her husband she would not be able to remarry on account of her age and especially because of her looks. She considered herself much older looking than her age. The patient received psychotherapy with amytal for about twenty sessons. In the beginning, suggestive treatment was applied to remove her symptoms, later on analytic technic was followed with free association. material gathered was then explained to the patient Se readily gained insight into some of her fears and eren though the explanations did not follow back the neurosis to its probable origin and paid more attention to the actual anxiety structure than to the infantile one, the patient rapidly lost her symptoms drored her husband remarried again and has been symptom free for the last two years

#### Comment

Different drugs can be used for narcotherapy Short-acting barbiturates are the best. We appove of sodium amytal or pentothal because the disinhibitory effect of these two drugs is superior to other barbiturates, but nembutal or evipan ran be used too Horsley requests that the drug wed should have a selective action on the hypothalmic region of the brain, that the drug should be safe and productive of a fair degree of narcosis without causing a serious clouding of consciousness. The narcosis is produced very slowly by injecting the drug gradually usually 3 to 10 grains of sodium amytal are sufficient. One grain n injected in about one minute. We keep the needle in the vein and start with the question immeshately injecting as much of the drug until the patient is somewhat drowsy but not actually deepy The patient should be in a state of pasave relaxation, able to understand fully what the therapist tells him and should be able to reply dearly When the patient begins to show nystag mus or the speech becomes slightly slurred, further injection of the drug should be discontinued If the patient should show a rapid recovery from the drug, further injection can be given later When the patient is in a state of relaxation, sug gestions can be given easily because of the hypnoid state which is produced by the drug Or, if the analytic approach is used the patient is asked to associate freely or to associate certain selected topics introduced by the therapist As the patient is in a state of hyperamnesia and inhibitions are removed usually forgotten memory ma teral is obtained easily and dissociations of memory, especially, and circumscribed amnesias are eliminated quickly The same thing is true for other dissociation mechanisms like hysterical con version. At the end of the amytal treatment it is best to give the patient suggestions for the lifting of some of the most outstanding symptoms like the anxiety or hysterical manifestations. salent factors in the neuroses have to be brought

out and the patient confronted with them. This synthesis can be done under the influence of amy tall or in separate sessions without using the drug. The treatment should be repeated about 2 to 3 times a week or if necessary even daily, until twenty sessions are reached. If the patient does not respond to twenty sessions it is not likely that the patient can respond to this form of psychotherapy. Other methods used in connection with other forms of psychotherapy such as recluention obviously are used in connection with amytal treatment, too.

The use of this form of psychotherapy in the civilian neuroses is still in an experimental state, even though especially in England, we have a number of reports on its use. To mention only a few Sargeant Slater Fraser, Stungo, and Horsley report favorable results.

At present we still know very little about the selection of patients for certain types of psychotherapy. It is obvious that not all cases need the same kind of treatment. In our experience with narcotherapy in various cases, we would tentatively say that this method is working well with the anxiety states and conversion hysterias as mentioned before.

In cases of anxiety hysteria and in the obsessive-compulsive neuroses the response is much less satisfactory even though in these patients an amelioration of symptoms can be achieved, at least temporarily. We did not treat character neuroses and sexual perversions by this method. Drug addicts and alcoholies were not included Gratifying were the results in some psychosoma tic cases of stomach ulcer tachycardia, and head injury. In these patients it was possible to detach the vegetative disturbances from the neurotic mechanisms and to relieve the patient of his symptoms of pain diarrhea, and headache. This method again demonstrates the fact that the su perficial neuroses respond to brief psychotherapy.

We do not want to imply that the patients we treated with narcotherapy would not have responded to ordinary psychotherapy but it would have taken a lot of time to accomplish this and many patients have neither the time nor the money to submit to extended psychotherapy. We know for instance, that in most clinics the treatment of the neuroses is unsatisfactory. The patient can be seen for only a short time and at infrequent periods. In these cases we believe that a trial can be made with the short form of psychotherapy.

It is obvious that the long range psychother apy with many sessions has great advantages over an abbreviated form of treatment. First, the time element is very important. If a patient is treated for two or three years, it is obvious that

it is much easier to influence him than if he is treated for a few weeks. Spontaneous recession of symptoms, which occur easily in two or three years in many neuroses, also can be booked to the credit side of a long treatment. This contingency will scarcely occur with short-term treatments.

A great advantage of a long-range psychotherapy, furthermore, is the lack of pressure under which the therapist works, it does not have to produce results quickly—It can be more circumspect and, being more active, would result in fewer mistakes It is obvious that the transference will be a much deeper one, and the chinging type of dependent patient would show more relief from symptoms on a prolonged form of treatment than otherwise, even though in this special group of patients, the long duration of the treatment is sometimes more of a liability than an asset The possibility of revamping and re educating the patient in a prolonged analytical procedure is much easier than otherwise The psychiatrist who uses short-term psychotherapy probably will have to be satisfied with symptomatic relief in many cases, and will be able to give only some, but not full, insight into the causative mechanisms of the individual neurosis It is obvious that a full immunization will not be achieved in all instances. but in many of the more superficial neuroses, this procedure will be sufficient, as it is astonishing to see how many neurotics respond to suggestive measures without needing lengthy treatment This short-term psychotherapy in connection with sodium amytal offers the following advan-It is short, less time-consuming, many more patients can be treated simultaneously, and financial burden on the patient is much less than with other types of treatment. This treatment form has three aspects (1) the diagnostic, (2) the therapeutic, and (3) the prognostic

The diagnosis of a neurosis is easier with sodium amytal than without it Under the influence of the drug, the patient is in a state of relaxation, inhibitions are lowered, the ability to speak is fostered, the establishment of a transference is rather quick, resistance is overcome much more quickly than without the sedation The ability of the patient to produce will be determined quickly Focal points of attack on the neurosis will reveal themselves quicker than otherwise The structure of a neurosis if not too deep-seated, can be reconstructed in a few sessions, and a decision can be reached quickly as to whether or not the neurosis is too deep-scated to be amenable for a short-term treatment

In observing the therapeutic aspect it is seen that the sodium amytal produces in the patient First, euphona Second, the breaking down of inhibitory mechanisms, therefore establishing

Third, the drug puts the rapid transference patient in a suggestible frame of mind under the influence of the drug are more suggest-Fourth, it demonstrates ible than otherwise to the patient the ability of the physician to control organic dysfunctions by relaxing the patient eliminating the conversion manifestations of anxiety, and freeing the patient from the hombard ment of sensory perceptions He, therefore. makes the patient free to concentrate on the treatment without giving him the excuse to dwell on the symptoms. Fifth, it has a strong appeal to the patient because it uses physical means of approach which the patient generally accepts more readily, based on his preconceived idea of a physician He also feels less isolated with his disorder because the treatments are partly medical, and he does not feel set apart having an emotional disorder instead of a physical one. This treatment is superior to hypnosis because in most of the patients a state of relaxation and suggestibility can be obtained, while hypnosis fails in many instances, especially with overanvious patients It has, furthermore, the great advantage that the patient does not give up the symptoms on a command, but, by a combination of suggestive and cathartic procedures, he gains some insight into the dynamics of the neurosis, which has more prophylactic value than a simple command hypnosis

We cannot state very much up to the present about the disadvantages of this form of therapy We are sure that it will fail in many cases in Honever, in which neurosis is quite ingrained such cases, even a very prolonged analytical treatment often fails Only extensive research will establish the criteria for one treatment or another, or will be able to demonstrate how many more patients are cured with the prolonged form of treatment compared with the short ones We believe that the failure with the short-term treatment does not do any extensive damage because a prolonged analytical treatment could always be instituted if the short type of treatment fails

Another danger of the treatment may be the patient's addiction to it. The relaxing effect of the barbiturate on tense, anxious individuals is great, and it is not impossible that some of them would crave the treatment more for the drug than for the psychologic help which is offered with it. Alcoholics and drug addicts, or persons who are addicted to sleeping medicine, are surely not suitable individuals for this type of treatment.

In cases of war neuroses we had no disagreeable experience. It was always possible to cut the drug transference in the same way as emotional transference. In the common neuroses, further studies have to be made on this point.

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# METABOLIC AND NUTRITIONAL ASPECTS OF ARTERIAL HYPERTENSION

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In the pathogenesis of arterial hypertension the circulatory blood volume seems to play a sguificant role. Increase in the circulatory blood volume is followed by an increase in the blood pressure, decrease of the circulatory blood volume is followed by a decrease in the blood pressure. Other factors also enter into the development of arterial hypertension, but the circulatory blood volume alone is distinguished by being more easily accessible to therapeutic approach.

Aming at the reduction of the circulatory blood volume the antiretentional diet was omployed. This diet is rich in proteins and vitasius, and is restricted to a greater or lesser extent in carbohydrates, fats, table salt, and liquids For a man of average height and weight and under ordinary living and working conditions, this det would consist of from 112 to 135 Gm. of proteins, from 150 to 260 Gm of carbohydrates, from 40 to 50 Gm. of fat, from 1 to 1½ L. of liquids (including the fluid content of fruits) and the smallest amount of table salt compatible with the enjoyment of the nical

Administration of this diet was followed by a reduction of the blood pressure in many instances <sup>1</sup> and the validity of the original observation was confirmed during the years in a great number of cases. The following are a few cases which serve as an illustration.

# Case Reports

Case 1—Mr D D aged 54 came under observation on October 23 1944 He was referred by unophthalmologist (Dr J Fried) whose findings conasted of a thrombosis of the central vein of the rerea. Hypertensive changes also were found in the e)egrounds. Physical and laboratory examinations showed normal results occept for a blood procesure of 169/98 mm. Antiretentional diot was administered and at the time of this report was still being followed by patient. The observations are summarized in the following table.

Ortober en	Blood Pressure	
October 23, 1944	160/98 mm.	Antiretentional dist be-
October 30, 1944 November 13, 1944 December 11, 1944 January 8, 1945 February 5, 1945 March 5, 1945	14/84 130/80 132/80 120/70 13°/80	<b>C</b> d¤
	116/76	Eyegrounds No hyper tensive hanges. All igns of thrombosis disappeared
ipril 16, 1943 Jane 18, 1945 Jagust 2" 194, Jagust 2" 194, Jorenber 14, 1946 Jane 10, 1946 Jorember 23, 1940	122/78 12*/78 133/82 122/80 132/9 118/80 124/80	agappeared

Case 2 — Ar M L. aged 47 came under observa too on May 1 1946. He was referred by an ophthalmologist (Dr. N. Nelson) because of hyper tensive changes of the eyegrounds. The patient said that two years previously he was told that he had high blood pressure. Examinations including chemical examinations of the blood showed normal results. The response of the blood pressure to the treatment was as follows

	Blood Pressure	
May 1 1046	180/100 mm.	Antiretentional diet be-
May 14, 1946	148/90	gun
May 28 1946	132/80	-
June 19 1046	138/90	
August 13 1916	134/90	
Bentember 10 1946	132/90	
October '9, 1946	132/00	Diet discontinued
December 3 1946	154/00	Antiretentional di t
		again ordered
Pahruary 12 1947	142/84	

Case 3 — Mr A. V., aged 47 came under observation on September 17 1046 He stated that the consultation was not prompted by any complaint on his part but because he was rojected by an insurance company several months proviously as a result of a blood pressure finding of 175 mm. The examination including chemical examination of the blood showed nothing noteworthy except hypertonsion Subsequently the following was observed.

	Blood Pressure	
Reptember 17 1946		Antiretentional di t
October 1 1946	154/100 148/98	
October 15 1946	138/80	
Oct ber 29 1946 November 19 1946	135/84	
January 4 1947	142 /90	Had insurance examina-
·		tion, blood pressure of 138 mm. found by in-
		urance physician

Case 4 — Dr A. W., agod 50 came under observation on May 17 1944. He complained of occasional cramps in the abdomen and distribed. His blood pressure had been high for soveral years past and usually ranged over 200 mm. The examinations revealed palpable peripheral arterial walls and a dilatation of the sortic arch. The blood chemistry was normal The everground showed arterial spasms. Yra, examination of the gastrointestinal tract and the gallbladder showed normal conditions. Subsequent observations were as follows.

	Blood Press re	
May 17 1944		Antiretentional dist
May *6, 1944	178/104	
Jun 2 1944	15/94	
June 9 1944	140/90	
June 23 1044	134/84	
July 7 1944	148/92	
August 11 1944	135/94	
September 1 1944	142/96	
Sept mber 25 1944	178/104	
October 2 1044	104/104	
\ rember 6 1944	170/104	
April 6, 1945	156/95	
April 11 1945	103/100	
May 23, 1945	144/88	
June 6 1945	162/100	

December 26 1945 168/100 April 19, 1946 148/92 September 28 1946 164/100 October 24 1946 154/98

Passed insurance examination with blood pressure of 138/90

Case 5—Mr H H, aged 42, came under observation on September 21, 1944 His blood pressure had been high for the past eight years, his systolic blood pressure was usually 190 mm while the diastolic blood pressure fluctuated between 140 and 160 mm Previous physical and laboratory examinations showed normal conditions. He had no subjective complaints. On examination, aside from hypertension, nothing unusual was found. The blood pressure readings were as follows.

	Blood Pressure	
September 21 1944	210/138 mm	
September 25 1944	198/136	Antiretentional diet
October 3 1944	164/110	
October 24 1944	158/108	
November 14 1944	156/112	
December 6 1944	152/108	
January 12 1945	158/112	
February 28 1945	156/110	
April 4 1945	154/110	
May 18 1945	162/110	Diet not observed
June 29, 1945	178/120	Diet not observed
August 15 1945	162/110	Diet not observed
June 27 1946	180/120	Diet not observed

The theoretical considerations with reference to the role of the circulatory blood volume in the pathogenesis of arterial hypertension and the practical results under discussion were confirmed by the observations of others in essential hypertension <sup>2-4</sup> as well as in hypertension in eclampsia of pregnancy<sup>5</sup> with the aid of the antiretentional diet<sup>2 3 5</sup> as well as by other means <sup>4 6</sup>

Additional confirmation of the significance of the circulatory blood volume in the pathogenesis and therapy of arterial hypertension also was found. When diabetes develops in the hypertensive patient, or when the blood sugar rises

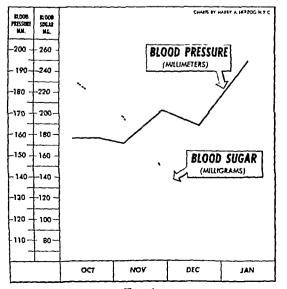


Fig 1

in the hypertensive diabetic, his blood pressure drops. If, then, the diabetes is brought under control with a decrease of the hyperglycemia the blood pressure remains at the lower level for a while but eventually it rises to the previous high or higher. In other words there is, in general, an inverse relationship between the blood sugar and the blood pressure in the sense that fluctuations of the blood sugar level are followed by fluctuations in the opposite direction of the blood pressure level.

Since the publication of these findings, two more cases were observed

Case 6—Mrs T R, aged 64, came under observation on October 8, 1946—She stated that she had had diabetes for the past seventeen years and recently was treated with a diet and 16 units of protamine zine insulin daily. Initial examination showed a blood sugar of 232 mg and urinary sugar of 18 per cent. By increasing the insulin gradually up to 32 units, the glycosuria disappeared and the blood sugar dropped to normal. For corresponding fluctuations in the blood pressure see Fig. 1

Case 7 -Mrs E S, aged 61, came under observa tion on June 14, 1946 Her diabetes was discovered sixteen years previously, and during the last five years she received treatment consisting of a diet and daily injection of 20 units of protamine zinc insulin On the initial examination there was no sugar in the urine and the blood sugar was 136 mg Because of obesity an attempt was made to reduce the body weight by reducing the caloric intake administration was reduced and subsequently dis continued on September 27, 1946 By reason of a rise in the blood sugar, which was considered undestrable, administration of 18 units of protamine zinc insulin was started again on October 4, 1946, with the result that the blood sugar returned to an almost normal level For corresponding changes in the blood pressure see Fig 2

One possible explanation of the phenomenon under discussion is that the diabetes produces an effect similar to antiretentional therapy. The antiretentional effect can be explained as being brought about, in diabetes, by the hyperglycemia which leads to glycosuma and the attendant poly-

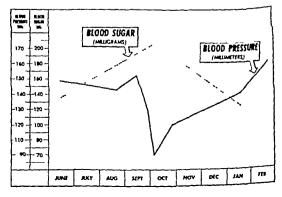
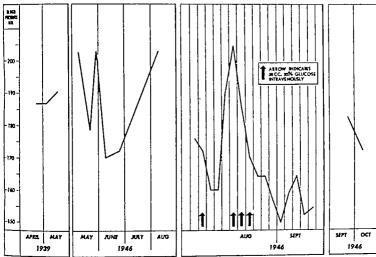


Fig 2



Fro 3

uria and thus causes a loss of liquids from the body and a reduction of the circulatory blood volume. And vice versa when the diabetes is brought under control the antiretentional effect stops and this eventually lends to an increased circulatory blood volume and to an increased blood pressure.

Another possible mechanism of the antiretentional effect of the hyperglycemia also deserves consideration In this connection two facts should be kept in mind The one is that there are glands of internal secretion which when stimulated increase both the blood sugar and the blood pressure Such a gland is the adrenal corter. The other fact to which attention is called is that as a general rule endocrine glands decrease their hormone output if such conditions prevail in the organism which the gland promotes and vice versa For example the gonadotropic hormone of the anterior pituitary stimulates the gonads If increased quantities of the androgenic or the estrogenic hormones circulate in the body due either to pathologic conditions or brought about artificially, the gonadotropic hormone output of the antenor pituitary usually diminishes conversely diminished function or removal of the gonada leads to increased anterior pituitary gona dotropic hormone output. Examples like these can be multiplied It seems then that when the blood sugar rises in the hypertensive diabetic the

the hormone output of the adrenal cortex (a gland which tends to raise the blood sugar) decreases. Decrease of the adrenal cortical function leads to increased elimination of sodium chloride from the body through the Lidneys and thus to a reduction of the circulator; blood volume and a reduction of the blood pressure

If the correctness of this reasoning is admitted the question arres as to whether therapeutic exploitation of this concept is feasible In particu lar an answer should be sought to the question of whether the blood pressure can be reduced in the nondiabetic hypertensive patient by raising the blood sugar, for instance by intravenous glu This seems to be a difficult if not cose injections hopeless undertaking in view of the fact that the hyperglycemia that is produced by this method But the attempt appears to be less ıs short lived honeless if consideration is given to the observation that the drop in the blood pressure which follows the rise of the blood sugar outlasts the duration of the latter? It would seem possible therefore that a series of intravenous glucose injections may lead to a reduction of the blood pressure which outlasts the injection therapy. In one case in which this concept was put to test the following was observed

Case S — Mrs. N 8 aged 58, first came under observation on April 20 1039 She complained of beadnehes and stated that high blood pressure had

been discovered five years previously A systolic murmur over the aorta was found, and a blood pressure reading of 186/100 mm was obtained tine treatment was applied, and on the two subsequent occasions, when she was seen in the year 1939, the blood pressure readings were 186/100 and 190/ 116 mm., respectively

She was seen again on May 9, 1946, complaining of a pressure in the chest and a choking sensation when walking An electrocardiogram showed concave ST1 and ST2 and a prominent Q3 Chemical examination of the blood showed normal The treatments and the corresponding blood pressure readings (See Fig 3) were as follows

ni . . . 1 n . . . . . . . . .

	Blood Pressure	
April 20 1939	186/100 mm 186/100	Routine treatment
May 4 1939		
May 18 1939	190/116	
May 9 1946	202/100	Antiretentional dict
May 22 1946	178/100	
May 29, 1946	202/100	
June 12 1946	170/90	
June 24 1946	172/90	
August 10 1946	202/100	
August 21 1946	176/90	
August 22 1946	172/90	20 cc 50 per cent glu-
•	•	cose intravenously
August 23 1946	160/76	
August 24 1946	160/76	
August 25 1946	190/80	
August 26 1946	204/100	20 cc 50 per cent glu-
110800000 1010		cose intravenously
August 27 1940	186/90	20 cc. 50 per cent glu-
11 ag 480 21 1010	100/00	cose intravenously
August 28 1946	170/76	20 cc 50 per cent glu-
11 dg d8t 25 10 to	110/10	cose intravenously
August 29 1946	164/80	cose intravendusi;
August 30 1946	164/90	
	156/80	
	150/80	
September 2 1946	158/84	
September 3 1946	164/84	
September 4 1946	152/84	
September 5 1946	154/80	
September 24 1946	182/90	
October 10 1946	172/90	

This patient was seen several times during the past seven years. When routine measures were applied, the blood pressure rose from the original 186/100 mm to 202/100 mm On antiretentional dietary treatment there was a drop in the blood pressure on most occasions, but never below 170/90 Following a single intravenous injection of glucose, the blood pressure, decreased to 160/76 mm for two days and then a rise occurred When the intravenous glucose injections were repeated on three successive days, a gradual drop in the blood pressure was observed, the lowest reading being 150/80 mm This drop was still present one week

after the last injection, but was not found when the patient was seen again three weeks later at which time a blood pressure reading of 182/90 mm was obtained

Obviously, a single case is no proof of the con cept and is not presented with that intention But the findings show a drop in the blood pressure following intrivenous glucose injections to a level which is not recorded during an observation of seven years Further, there was a drop in the blood pressure following intravenous glucose in jections on two occasions It is noten orthy that the blood pressure dropped after one injection to a lesser extent than after three injections It also should be considered that subsequently the blood pressure rose to approximately the previous level on both occasions, but remained at the low level for a shorter period after one injection than after three injections These facts and the fact that the phenomena observed are in accord with the theory are suggestive and make further experimentation desirable

# Summary

- Dietetic (antiretentional) treatment is frequently effective in arterial hypertension
- Fluctuations in the blood sugar level are followed by fluctuations in the opposite direction in the blood pressure level of the hypertensive diabetic
- In one case of (nondiabetic) essential hypertension intravenous glucose injections were followed by a drop in the blood pressure
- All of these phenomena are in accord with and are derived from a theory of arterial hypertension which considers the significance of the circulatory blood volume

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#### CONGRESS DELUGED WITH HEALTH BILLS

Dr Joseph S Lawrence, director of the American Medical Association's Washington office, reports that 132 bills and resolutions pertaining to health and medical practice were introduced in the last Congress Of this number, 51 were introduced in the Senate and 81 in the House

Thirty-six of these had identical companions in the other House, 21 were accorded hearings before

Senate committees and 35 before House committees Of those having hearings, 19 Senate and 21 House bills were reported to their respective floors and 15 passed the Senate while only 11 passed the House Of these, three Senate bills, five House bills, and one joint resolution passed both Houses and with one exception became law -Secretary's Letter, American Medical Association, October 20, 1947

#### THE NATURE OF ACUTE LEUKEMIA AND THE INTERRELATION SHIP OF THE MALIGNANT DYSCRASIAS

ROBERT D BARNARD M.D Laurelton, Long Island

A RECENT editorial has stressed the appar A ent increase in leukemia mortality 1 There is no breakdown in available statistics into scute and chrome types Difficulty is sometimes encountered in such specification because of the lack of agreement in classification of transitional cases, leukemia, like other neoplastic diseases, shading from cases actually approaching benign ancy to those of fulminant malignancy bukema may be malignant only "by virtue of stustion,' the ucoplastic cells exerting their deleterious action mechanically by crowding out ntal parenchyma. Such cells however are easily asseptible to radiation or other curbing influence to that protracted remission may be procured Systemic cholinergic into ucation, the feature of the malignant dyserasias which kills is not prominent in chronic leukoses, but chronic leukemes may revert to and die of a pathodynamic requence comparable to that which operates in acute leukoses This further complicates statistical evaluation

The practicing physician however, is less concerned with statistics and terminologic nicetics than he is with the fact that one out of every thousand children is carmarked for death from one of the malignant dyscrasias From lus stand point chronic leukemia is not nearly so tragic as is the acute form. He knows that in the former the patients have time for adjustment and resig nation following attainment of which the patient may hve for years. Acute leukemia on the other hand, poses a heart-rending problem with which every physician is familiar But its dominant importance transcends the drainatic feature of hopelessness. Since it forms the terminal stage and mode of all leukemin, development of successful therapy for acute leukemin should solve the entire leukemia problem. For though we do not know the cause of chronic leukernia which appears to be a primary neoplastic discuse its han ding is rather more relevant to the cancer problem than to the one which we will discuss. Acute leukemia, on the other hand is a reactive or second ary neoplastic disease, the cause of which may actually be close to elucidation The explanation of the paradox that we can do something for the counterpart whose cause remains unfathomed lies in the fact that we are dealing with purely mechanical pathodynamics in the case of chronic leukemia and that it is simple by x ray or other irradiation to decelerate the pathodynamic sequence Perhaps by an appreciation that this sequence is altogether different in acute leukemia more success would attend our efforts in the Inttor

It is the purpose of this report to discuss par ticularly the pathodynamics of acute leukemia since the mechanism of death in this disease is identical with that of almost all the other malic nant hematologic dyscrasias. Such a discussion is a necessary preliminary to any approach toward rational therapy

The procedure against acute leukemia has al ways been based on morphologic considerations because the morphologist continues to dominate the hematologic field To the morphologist there appeared to be the same type of marrow hyperplasia or neoplasia that characterized the chronic leukemias and this "hyperplasia would have to be dealt with in the same manner by curbing or stifling the fractious proliferation With universal failure attending this approach warnings have been sounded particularly by Goldman 3 that physiologic considerations were being ignored True, an attempt was made to apply the results of Miller and Turner who found a possible underlying metabolic abnormality to therapy with myelokentric acid but here again the object was destruction of myeloblasts and stall the children died . Folic acid therapy did have a physiologic connotation but it was applied as a hit or miss supportive expedient and there is a reasonable expla nation of why it in turn has failed

Nevertheless, strictly physiologic considera tions were emerging from the background classic works of Sabine and Davis on cholinester ase and studies on phosphatase abnormalities in certain blood dyserisins have been published 6.6 simultaneously and independently Schwind and the author's group at Halloran General Hospitals administered plasma to leukotics with def mitely salubnous effects. The evaluation of the latter by Schwind although on a morphologic basis was, nevertheless, physiologic since the criterion was myeloblastic maturation rather than destruction The author and his coworkers rehed on general chincal appraisal having given massive plasma doses to replenish the depleted blood cholinesterase that characterizes all the malignant dyscrasias.

This approach had been mandated by consider ations developing over a period of years, consid

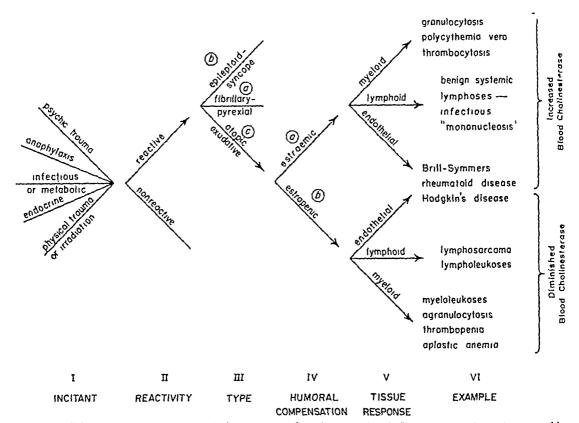


Fig 1 Schematic representation of the course and pathways of r cholinergic episode and its possible culmination in one of the acute malignant hematologic dyserasias

erations whose implications have wide application to clinical medicine and, therefore, are developed in some detail They permit the premise that acute leukemia is one example of a series of peculiar and infrequent but still physiologic, constitutional reactions to what has been termed a cholinergic episode The latter, in turn, may be defined as a medical or surgical event which is followed or accompanied by evidences of parasympathetic autonomic activity in a reactive Only a small percentage of humans are so reactive, blood donor syncope, which was chronologically the first cholinergic episode to be thus defined, affects only about 7 per cent of those who subject themselves to actual or anticipated blood donation and this minor fraction, alone, reacts to the (psychogenic) cholinergic stimulus by convulsions and/or frinting The last is an example of a cholinergic reaction and this, if sufficiently protracted (as in suigical shock) may be referred to as a cholinergic state

The diverse but still composite convergent instrumentalities that may operate, individually or conjointly, to constitute a cholinergic incitant are depicted in Section I of the diagram of Fig 1, for example, any of the following—a trivial surgical procedure, typhoid vaccination, a localized or generalized infection, or the transient estripenia (reduction in blood cholinesterase) produced by ridiation, might set off the divergent lamifications of cholinergic reaction, one of whose terminations could be death from acute leukemia. This eventuality, though rare, seems to follow the specific pathway indicated in the diagram. The latter, it must be emphasized, is far from complete, though it does permit formalization of the actual interrelationship of the dyscrasias. The potential pathways will be traced to their various terminations.

(Section II, Fig 1) That the instrumentalities listed as precipitants of cholinergic reactions fail to excite such reactions in the majority of instances is due to the fact that only a small minority of humans are cholinergic reactors, where they occur in the life of an individual who is not a reactor, they do not constitute cholinergic stimuli and there has been no cholinergic episode. This answers the question frequently raised as to why everyone getting typhoid vaccine does not succumb to acute leukemia. Only a few people aspirating virulent pneumococci will develop lobar pneumonia.

Where cholinergic reaction occurs it appears to be due to the circulation of parasympathomi

metic substances (acetylcholine, iminazolyl gnamidal and/or peptono denvatives) which may be demonstrated by appropriate tests of the reactar' blood. The signified cholinergic intovaration manifests itself in one or a combination of three types of reaction shown in Section III of Fig. 1.

(IIIa) A fibrillary-py rexial reaction classically the 'chills and fever' syndrome sometimes accompanied by pressor manifestations or tetany

(IIIb) An epiloptoid-syncope reaction consisting of swooning with or without a convulsive phase and attended by diaphoresis and pallor, as in blood donor syncope or surgical shock.

(IIIe) The atopic-exudative reaction is that which will be elaborated, for it is in this direction that a cholinergic reaction must proceed to culminate in one of the malignant dyscrasias pes (and the term is used here in the sense of a constitutional 'allergic diathesis'') need not be conditioned by any previous, specific rensitization ton but may become manifest as a result of any of the cholinergic incitants, e.g., "emotional aller Atomic reactions are the only cholinergic reactions where tissue changes may be overt and this feature accounts for exudative phenomena which are so frequent Purpure termination of scute leukemia is the result of hemorrhagic exudation due to an increase in blood heparin exactly comparable to that extant in anaphylactic pur Dom

Atopy has a unique effect upon bone marrow function. Leukopenia is the rule in acute anaphylaxis and we now regard leukopenia as a sign of marrow depression.

In the compensatory phase of most allerge states, the cosmophilic myeloid elements show selective, proliferative tendencies which accounts for the eosinophilia and suggests that in this phase there is some degree of marrow stimulation. The evidence for the last connotation of cosmophilia is indirect and somewhat involved and concerns us here only in that it furnishes an example of myeloid dissociation," a phenomenon that reaches culminative example in acute leukemia and constitutes the block upon which the morphologic school appears to have stimbled

Under ordinary circumstances the three mycloid elements mycloblasts, erythroblasts, and megalanyocytes elaborate their perpheral end products in surprisingly uniform ratio and in a harmony that indicates the close relationship that must exist among the three cellular elements concerned in hemoporeus. This concomitance extends to the majority of hematologic conditions. In polycythemia where there is known crythroblastic hyperactivity, there is in addition to the crythroma an absolute leukocytosis and throm bocytosis as well. In fact, the ultimate ratios

obtaining among the peripheral inveloid elements of poly eythemic blood are about those of normal blood. The blood cholinesterase concentration (which is the most accurate index of crythropoietic activity) is also increased.

In those two conditions where pan-marrow hypoactivity is acknowledged aplastic and mac receive anemias there is a proportionate drop in granulocytes and platelets. A similar concomitance can be traced through certain obscuring features of other hematologic conditions. In hemolytic anemia or that of chronic blood loss, though the red cell concentration may be reduced the simultaneously accelerated crythropoiesis is accompanied by increased granulocyte thrombocyte, and cholinesterase production

Seldom except in the leukemias does this relationship not obtain, and even in the dissociation' of leukemia the inherent concomitance of my cloud function is indicated by cholinesterase studies.

Cholmesterase production, a myeloid function is the humoral barrier to cholinergic intoxication When a cholinergic episode has occurred the blood of the reactor is flooded with aretylcholinelike substances an attempt at compensation takes the form of a call upon the bone marrow for greater cholinesteruse production If the need is met (IVb) the cholinergic intoxication is vitiated and, even if the cholinergic incitant persusts, its effects will be curtailed by the estrema (increased blood cholinesterace) and it will never attain a malignant degree Examples of this transpiration are furnished by the chronic allergies, benign systemic lymphoses ( 'infectious mononucleosis'') and the rheumatoid diseases

But there is another possibility Suppose that a cholinergic episode (I) occurs in the life of a reactor (II) whose constitutional predisposition mandates the atopic response (III) and there is failure of humoral compensation (IVa) exactly will then occur? The answer appeared simultaneously from studies of two different and apparently unrelated dyscrasias Davis work ing with dogs poisoned by acetylcholine found a macrocytic anemia and estrapenia. Human permicious anemia patients also showed an estra penia and a reciprocally increased blood acetyl choline content 11 The author's group im pressed by the pronounced cholmergic features of acute leukemia (whereby these patients exhibited the symptoms that one night expect if both acetylcholine and an anaphylactogen were being pumped into their veins) found an estrapenia proportional to the acuity and chinical severity of the condition 12 Estrapenia of a degree sufficient in itself to account for the cholinergic intoxication was likewise found to be a feature of the known hypoplastic dyserasias Acute leukemia in this

sense, appeared to be a marrow hypoplastic condition in spite of the plentitude of immature myeloid forms of cells extant In other words, morphologic and physiologic criteria of marrow There is, however, an activity were at variance adequate explanation for this variance

It now appears that the unhampered circulation of cholinergic substances, which have the chemical common property characteristics of protoplasmic poisons, 13 in an atopic type of reactor, will depress the bone marrow and particularly that function of the marrow which has to do with elaboration of blood cholinesterase Thus, there will arise a vicious circle of progressive estrapenia and further cholinergic intoxication which constitutes the alternative response to compen-In other words, if there is not a reaction to cholinergesis in a compensatory manner, by estrema, the atopic reactor must inevitably react in the opposite manner, by estrapenia, which introduces a spiral of further cholinergesis leading to cholinergic decompensation (IVa)

The last response is a malignant one linergic into ication having overcome the humoral defenses, the last stronghold remains that of the phylogenetically older and less appropriate cellular defenses The outcome of the struggle will depend on whether the tissues are apathetic or make the effort borne of desperation, in either event tissue changes must occur The nature of such changes are indicated, in so far as the hemopoietic and related tissues are concerned, in sections V and VI of Fig 1 One in whom potentiality for myeloid proliferation remains will make a vicarious and indiscriminate response toward hemopoiesis, this falls short because the lone cell produced, which is the myeloblast, does not engender a cholmesterase-containing series fact, all that myeloblastic proliferation in acute leukemia succeeds in is snarling what ancillary defenses remain to the body and the result is for-A more fortunate myeloid response is that which occurs in agranulocytosis or thrombopenia, for here the situation is not irretrievable the point to be made is that we have succeeded in developing a category of myeloid responses to the estrapenic atopic episodes, and that this category includes the agranulocytoses, thrombocytoses, aplastic anemias, and aleukemic, and leu kemic myeloid leukoses which are, in fact, tran sition forms of the same fundamental process. The unity among these conditions has been obscured by apparent morphologic diversity

Where the tissue response, arising in the wake of humoral cholinergic decompensation, is lymphoid, lymphosarcoma or acute leukemic lymphoblustosis is the morphologic result. Evidently these conditions are basically related to the malig nant myeloid dyscrasias, a relationship that is reflected in their practical clinical identity with the latter An endothelial response, in turn, will elaborate those varients of the malignant dyscrasias that are now grouped for classification in the category of Hodgkin's discase But the intrinsic fundamentality of their interrelationship with the malignant myeloid and lymphoid dysemsias is an entrancing avenue of approach to the goal of successful therapy

## Summary and Conclusions

By tracing out the multiplicity of pathways that a cholinergic chain reaction may take and by taking into account the role of constitution reactivity in the selection of these pathways, it is possible to show a fundamental interrelationship of all the malignant, hematologic dyscrasias Differences which appear to exist among them, such as those of morphologic constituency, may be merely minor reflections of differences in tissue response to humoral cholinergic decompensation

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#### POSTGRADUATE **FELLOW SHIPS AVAILABLE**

The National Jewish Hospital at Denver announces a program of fellowships for postgraduate study in tuberculosis and allied diseases will be appointed for three month, six month, or one year periods

Information regarding the fellowships can be

obtained by writing to Dr Edgar Wiver, chairman, National Medical Advisory Board, National Jewish Hospital at Denver, 470 Park Avenue, New York City, or to Dr Allan Hurst, medical director, National Jewish Hospital at Denver, 3800 East Colfax Avenue, Denver 6, Colorado

## ALLERGIC REACTION TO PENICILLIN

## MAXWELL L GELFAND M.D New York

Bellevue Tosputal, Fourth Medical Division)

TOLIC symptoms following the use of penicillin have been observed by many who have employed the valuable antibiotic in a variety of clinical con ditions.1-7 Mild reactions, such as a transient urticaria\*3 to very severe alarming symptoms resembling anaphylactic shock appear in the volumi nous literature 19-12 on penicillin therapy and its reactions.

The following case is reported as one presenting many of the serious allergic reactions with favorable response to the withdrawal of the drug and the use of an antihistaminic preparation, pyribenzamine.

#### Case Report

Mrs. A. S. a white woman, aged 28 was admitted to the maternity ward of the Manhattan General flopital on December 24, 1946 in active labor She had a normal apontaneous delivery four hours On December 27 a rise in temperature to 102.4 F, without any untoward symposised to moted. Thorough physical examination failed to foodings. At 10 00 PM. of reveal any abnormal findings. At 10 00 PM. of the same day she was given 300 000 units of penicillin in beeswax, intramuscularly On the morning of the twenty-eighth her temperature was normal and the drug was discontinued.

That same evening a rise to 102 F was apparent again. The patient immediately received, intra muscularly, 50 000 units of sodium peniculin dussolved in physiologic saline and 30 000 units overy three hours thereafter On December 29 the patient complained of headache malaree myalgia, and intense itching over the face neck and body Edema of the dorsal surface of the hands, and pains in the wrists and ankles developed that night The following day constriction of the chest cough, and wheezing appeared. A complete gynecologic examination at this time failed to disclose any abnormalities,

On January 2, 1947 when first called to examine the patient I found her to be lethargic, listless, and complaining of sovere generalized myalgia, arthraigia of the wrate and ankles, and severe headache The following abnormal indings were present subconjunctival hemorrhages in the lateral margins of both eyes a diffuse maculopapular desquamat ing rath over the lateral aspects of the face, need chest trunk thighs, and legs, many rhonchi and sonorous and sibilant rales throughout the chest on susceptibilities. auscultation edema of the wrists, fingers, and ankles, particularly over the dorsal surfaces. There was no nuchal ngidity or other evidence of meningeal pritation. Her heart and abdomen were

negative and no adenopathy was discernible.

The blood count on December 27, 1946 revealed a red blood cell count of 3 750 000 and a hemogloban content of 78 per cent. The white cell count was 13 500 with 80 per cent polymorphonuclear leukocytes of which 10 per cent were nonegmented monocytes were 2 per cent and lymphocytes were 17 per cent. Urinalysis disclosed a specific gravity of 1 034 2 plus albumin, 1 plus sugar and the complete c augar and many rod blood cells with a few white blood corpuscles. A second blood count on January 2, 1047 showed the following red cells, 8 480,000

with 68 per cent hemoglobin content, white cells, 18 000 with 80 per cent polymorphonuclear leukocytes of which 6 per cent were nonsegmented, the monocytes were 2 per cent and lymphocytes were 18 per cent The urine examination on this day was normal.

The patient denied any past history of allergy drug reaction or idiosyncrasy and other than a past history of epidermophytoms of her toos, she had proviously enjoyed good health. She had no knowledge of ever receiving penicillin in any form. Her family history was negative to any of the known allergic diseases. Other drugs given in addition to penicillin were codeme aspirm and stilbestrol

The diagnosis of toxic reaction to penicillin was suspected from the history and physical examina-tion. The penicillin was stopped immediately and 150 mg of pyribenzamine in divided doses of 50 mg, were given daily improvement both objective and subjective was ordent in forty-eight hours. She continued to improve thereafter and was discharged on February 8 1947 six days after the cessation of the drug The desquamation of the skin and edema continued for two weeks after dis-Codeine charge and then cleared completely aspirin and stillbestrol were given again on the day before leaving the hospital without any ill effects.

Skin tests with sodium penicillin and molds were performed intradermally and the results appear in Tables 1 and 2 Passive transfer with the patient s serum was negative.

#### TABLE 1

Dfluting fluid Sodium pentellin—dflution 1:1,000 Sodium pentellin—dflution 1:100 Sodium pentellin—dflution 1:10 Sodium pentellin—dflution 1:10 Concentrated pentellin (1 cc. equals 40:000 units)	Negative Negative Negative Negative
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#### TABLE 2

TABLE 2				
Diluting fluid Pericellinm—1,000 units Monilla—1,000 units Hormodendroo—1 000 units Appergillus—1,000 units Alternaris—1,000 units Alternaris—1 000 units Mucor—1 000 units Domatlum—1 000 unit Teast—1 000 units Output of the control	Negative			

#### Comment

There is sufficient experimental and clinical evi dence to show that both commercial and crystellips penicilin have definite antigenic and allergenic properties.13 14 Whether it is due wholly or par tually to the impurities in the commercial product cannot be answered as yet However it is very evi dent that since improved technics of removing im purities from penicillin have been developed fewer reactions have been reported

Hypersensitivity to penicillin may manifest itself as an immediate or delayed reaction.4 Those who have a past history of exposure to penicillin will give an immediate reaction Delayed reactions are those in which allergic symptoms appear several hours to several days after contact with the allergen There are two types of such reactions, namely, (1) the inflammatory type, and (2) the delayed edema The delayed edema reaction gives negative direct and passive transfer skin reactions and is in no way related to serum disease 15

This patient manifested her symptoms twentyfour hours after the first injection of penicillin Because of this, and signs in which cdema was the outstanding feature, it falls in the class of delayed reaction of the edematous type The negative direct and indirect skin tests are in conformity with the expectancy in this type of reaction The previous trichophyton infection may have sensitized her tissues

Jadassohn, Schaaf, and Wohler, working with trichophytons by the Schultz-Dale technic, concluded that fungi have a common antigenic factor in addition to antigenic factors peculiar to each species 16 However, Feinberg found that patients sensitive to the spore penicillium did not give any positive skin reaction to penicillin 17

The additional medication did not in any way contribute to this reaction, as evidenced by the fact that the reintroduction of these drugs produced no The relief of the symptoms of untoward effect pruntus, myalgia, arthralgia, and edema was striking after the administration of pyribenzamine However, it should be noted that the improvement lasted only a few hours after each dose of medicament, hence the need for its daily use in divided dosage It is conceded that the withdrawal of penicillin is most important in controlling the allergic reaction

#### Summary

- 1' A case of postpartum fever treated with penicillin and developing an allergic reaction of the delayed edematous type is presented
- Severe symptoms of fever, headache, listlese ness, myalgia, arthralgia, desquamating skin rash, edema, bronchial asthin, and subconjunctival homorrhages, developing in a single patient, makes this case somewhat unusual
- Direct skin and passive transfer tests with penicillin were negative
- Relief was obtained after withdrawal of peni cillin and administration of pyribenzamine

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## PROGRAM FOR A M A SESSION

The Council on Scientific Assembly of the A-MA has prepared the program for the interim session at Cleveland, January 5-8, 1948 There will be a full-scale scientific program especially designed for the general practitioner and an excellent program by the Congress on Industrial Health for physicians and others interested in industrial health

The general scientific meeting at Cleveland will include the following papers "Peptic Ulcer," Frank H Lahey, M D, Boston, "Recent Advances in Hematology," by Carl V Moore, M D, St Louis, and "The Chronic Invalid," by Edward L Bortz, MD, Philadelphia, president of the

The program also will include several panel dis-

cussions One deals with the care of posthospitalized patients with cancer Charles C Lund, M D.

Boston, is the moderator Another discussion will concern the treatment of the ambulators and hospitalized discharge and the concern that the concern the concern the treatment of the ambulators and hospitalized discharge and the concern that the care of posthospitalized posthospitaliz hospitalized diabetic patient, with Elhott P Joshn, MD, Boston, serving as moderator panel will be held on the treatment of pathologic disturbances of adolescence, with Joseph A John ston, MD, Detroit, as moderator A fourth panel discussion will deal with uterine hemorrhage Karl H Martzloff, M D, of Portland, Oregon, will be the moderator

A symposium on multiple injuries in automobile accidents also is planned, with Luke B Jackson,

M D, of San Antonio, presiding

#### SPONTANEOUS RUPTURE OF THE VENTRICULAR WALL WITH CARDIAC TAMPONADE FOLLOWING CORONARY OCCLUSION AND INFARCTION

WILLIAM B RAWLS, M.D., ROBERT A. O. CONNOR, M.D. and VINCENT A. NARDIBLIO JR., M.D., New York City

(From the Medical Services of St. Clare & Hospital)

ALTHOUGH 5 to 10 per cent of patients with myocardial infarction of major proportions are reported in the literature to have rupture of the ventucular wall, the diagnosis very seldom is made during life Further, we believe its occurrence within fifteen hours of occlusion is sufficiently rare to warrant report of this case

#### Case Report

8. K., a white woman aged 59 was admitted to St Clares Hospital at 6 00 PM on February 6 with the chief complaint of pain in the epigastrium of three hours duration At three o clock, while en route to the hospital to visit a friend the patient un to catch a trolley car and experienced sudden excudiating pain in the epigastrium. The pain was less intense a few minutes after boarding the car and she was able to continue the trip She was more comfortable after resting a short time in her Inends room, but suddenly while sitting quietly three hours later the pain became excruciating again, she was nauseated and vomited. She was sen immediately by an attending physician and put to bed. There was a history of gastric ulcer gallbladder disease and, recently, distress after eating fatty foods but no history of heart disease or pain prior to the experience described

Physical examination revealed an elderly woman who appeared to be acutely ill and in moderate shock with second-degree cyanosis of the lips. pulse was 95 and regular respirations 35 and tem-Perature 98.6 F The blood pressure was 170/110 The heart sounds were of fair quality nortic second sound was increased over the pulmonic second tound and there were no organic murmurs or thrills. On percussion the heart appeared to be enlarged. The radial arteries revealed third-degree arterioscleroes to be present. There was marked tender ness in the epigastric region with moderate splinting of the muscles.

Laboratory Data —Hemoglobin was 100 per cent erythrocytes were 5 100 000 leukocytes, 11 400 polymorphonuclears 85 per cent (all segmented), and lymphocytes, 16 per cent Urinalvais showed an acid reaction, with a specific gravity of 1019 a slight trace of albumin but no red blood cells, sugar of the control sight trace of albumin but no red blood cells, sugar or action. The electrocardiogram revealed sinus arrhythmia. The rate was 95 per minute, conduction times were normal. There were left axis deration small Q waves in lead I and large Q waves in lead IV. The RT segments appeared to be alightly elevated in lead I, depressed in leads II and III and high in lead IV (Fig. 1). After completion, the examinations, which re-

After completing the examinations, which required approximately one hour it was decided that we were dealing with a coronary occlusion. With bed rest aminophyllme morphine and oxygen the patient was quite comfortable and for eight hours appeared in fair condition Suddenly she became evanute and the suddenly she became cyanotic and very restless, the pulse rose to 120 and respirations to 45. The oxygen volume was increased and her condition was somewhat improved

the pulse decreased to 106 and respirations to 45 Three hours later there was a sudden return of the evancers and the patient became comatose with the radial pulse imperceptible and respirations labored. The heart sounds were audible but the rate was too rapid to count by stethoscope Intravenous aminophylline was given immediately and the oxygen was Increased to 16 L. per minute but ten minutes later the patient expired

Posimortem Examination —The heart weighed 890

The pericardial sac contained a small amount of dark fluid blood and large blood clots, dark red and jelly-like in appearance which weighed approximately 90 Gm. There was a mottled, hemor rhagic, softened area 41/2 cm by 3 cm. situated near the apex in the anterior wall of the left ven-There was a gray firm thrombus in the descending left coronary artery about 1 inch distal to the estium completely blocking the lumen. The right and left coronary arteries and right circumflex branch showed a moderate amount of arteriosclerosis but no evidence of any thrombi. The pulmonic and aortic valves were somewhat thick ened there were adhesions of the commissures and a moderate amount of arteriosclerosis in the region of the sinus of Valsalva. There was some thickening of the mitral valve edges and curling and thick ening of the chordec tendinene The lungs showed a moderate amount of congestion with no evidence of consolidation

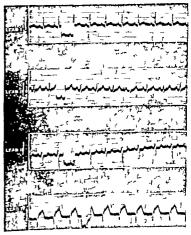


Fig 1

The gastrointestinal tract was normal The spleen weighed 250 Gm, its pulp was dark red on section and the malpighian bodies were visible. The kidneys weighed 320 Gm. The capsule stripped with ease, leaving a smooth surface on which there were several large retention cysts containing clear, straw-colored urine. The cortex and medulla were markedly congested with distinct markings. The mucosa of the pelvis and uterus was normal. The liver weighed 1700 Gm, the capsule was smooth and the edges sharp. On section it was reddish-brown and rubbery with no distinct markings. The gallbladder was distended, multiloculated, and contained dark-greenish, viscid bile and fifteen stones varying in size from 1/2 cm to 3 by 2 cm. The adrenals and pancreas were normal.

The anatomic diagnosis was (1) arteriosclerosis of the coronary arteries, (2) occlusion of left descending coronary artery with fresh infarction of the anterior wall of the left ventricle and minute spontaneous perforations, (3) hemopericardium, (4) tamponade of the heart, (5) generalized arteriosclerosis, congestion of the viscera, chololithiasis,

multiple retention cysts of both kidneys

### Discussion

In this instance we were faced with a problem in differential diagnosis in a patient, first seen when acutely ill, who had a past history of gastric ulcer and chololithiasis with a chief complaint of sudden, excruciating pain in the epigastric region. Possible diagnoses to be considered were coronary occlusion, ruptured gastric ulcer, chololithiasis, or ruptured gallbladder. She was treated as a possible coronary occlusion with the exception that morphine was not given until we believed we had eliminated the possibility of ruptured gastric ulcer or ruptured gallbladder.

Rupture of the ventricle is not too infrequent and the usual cause is arteriosclerosis of the coronary arteries leading to local necrosis and aneurysmal dilatation of the mycoardial wall. The rupture frequently occurs on the anterior wall of the left ventricle as in this case. Other etiologic factors may be syphilitic gummata or pyogenic abscess. Rupture of the ventricle generally occurs within the first two weeks or, most frequently, at the end of the first week after an occlusion and is a very rare occurrence on the first day. However, coronary occlusion may be comparatively asymptomatic at times, and there were no indicative symptoms in this case before the patient ran for the strecter fifteen hours before death.

Therefore, it is difficult to determine whether the excrtion described precipitated a coronary occlusion or rupture of the ventricular wall. If a silent occlusion had occurred previous to this episode, the rupture might have taken place when the first excruciating pain was experienced, and the tamponade effect prolonged life for fifteen hours On the other hand, if the occlusion occurred when she ran for the car, rupture of the ventricular wall may not have taken place until the attack of nausea and vomiting three hours later, and the tamponade effect then prolonged life for twelve hours A third possibility is that rupture occurred with the first circulatory failure which took place twelve hours after the original symptoms, and then the tamponade effect prolonged life for only three hours However, there were no symptoms to indicate that occlusion occurred before the original event described, and, if this be true, then rupture occurred within fifteen hours of occlusion, which is extremely rare

# COLUMBIA RECEIVES GRANTS FOR STUDY ON GLUTAMIC ACID

Columbia University has been awarded grants totaling \$39,000 from two New York foundations for further study on the use of glutamic acid, it was announced recently. Joint gifts of \$6,500 a year over a three year period were awarded the University by the Rockefeller Foundation and the New York Foundation.

Early this year, three Columbia University scientists reported that evidence exists that glutamic acid may in some cases boost the mental powers of children who have relatively high I Q 's, but who also have some organic difficulty such as anywhere days to prote the party of the control of

onvulsions due to petit mal, a form of epilepsy The foundations stipulated that the funds be d for work in brain chemistry, which will be carried on by Dr Heinrich Waelsch at the New York State Psychiatric Institute and Hospital

Dr Waelsch, attached to the department of biochemistry, Columbia University, College of Physicians and Surgeons, and other scientists at the University, have reported that extra amounts of glutamic acid—a substance produced by the human brain—may in some cases increase the mental and physical alertness of epileptic patients

It was pointed out, however, that the scientists are making no claims that they have found a brain food which can be given indiscriminately to raise a person's I Q. They explained that such treatment demands careful observation and management, with each case requiring special handling



#### CONFERENCES ON THERAPY

# DEPARTMENTS OF PHARMACOLOGY AND MEDICINE CORNELL UNIVERSITY MEDICAL COLLEGE AND THE NEW YORK HOSPITAL

THESE are stenographic reports of conferences by the members of the Departments of Pharmacology and of Medicine of Cornell University Medical College and New York Hospital with collaboration of other departments and institutions. The questions and discussions involve participation by members of the staff of the college and hospital students, and visitors. A selected group of these conferences is published in an annual volume Cornell Conferences on Therapy by the Mucmillan Company.

### An Optimal Routine for the Management of Congestive Failure

DR McKeen Cattell Today, an expert in the field of the management of heart disease will tell us how he treats congestive failure. The topic will be introduced by Dr Gold

Dr. Harry Gold In the past few years we have been pursuing a plan for the treatment of congestive failure, which seems to be yielding better results than any system in common we with which we are familiar. We now advocate this system for routine use and it seemed desirable to give it an airing in one of these conferences. I have discovered that this is not a bad way to learn something of the potentialities for survival of a therapoutic procedure.

The system consists of two parts—one, to abolish an attack of congestive failure and the other to establish an adequate plan to prevent its recurrence—In principle, we aim to establish in the patient with congestive failure a state which we term the dry weight. By this term, we mean a state in which the optimum amount of extracellular fluid remains

There are five cardinal points in the plan The patient is put at bed rest, or at rest in a chair depending on which seems preferable. The diet consists solely of four to six glasses of milk daily The patient receives at least two quarts of water daily, a glassful every two to three hours If the patient has not had digitalis recently he receives 1.2 mg of digitoxin or digitalin Nativelle at one time followed by 0.2 mg daily for maintenance. A dose of mercuhy dran is given intramuscularly and is repeated daily The course is guided by a record of the body weight. The patient is weighed before the treatment is started, then every day thereafter and the weight charted. This system is continued until all gross signs of edema disappear and the body weight reaches a resistant level below which it will not go with the continued use of the daily dose of the mer

The patient may now become ambulant and a plan is worked out for the purpose of mainte-

nance. In principle we do the following. We increase the diet, we make it more liberal so as to include practically all articles of food, withholding salt from the cooking and at the table. We con tinue the 0.2 mg, dose of digitorin daily free intake of water is also continued terval between the injections of the mercurial is now prolonged to every other day for three or four doses. If the daily weight continues to show a constant level, we increase the interval to every third day In this way we continue to prolong the interval until we find the longest interval between injections which is possible without an abrupt use of the body weight before the in section and without a conspicuous fall after the injection This establishes the maintenance interval and may be continued indefinitely the course of time, it often becomes possible or necessary to make further adjustments. The maintenance of the 'dry' body weight is the There are choices of maintenance plans.

This is the essence of the system we use. The secret of its success lies in the manner in which the details are carried out

Dn. Cattell. There are a number of experts here who are concerned with the treatment of heart disease. Perhaps we might first get their reaction to what has been said before opening the subject for general discussion. Dr. Eggleston, have you a comment?

Dr. Carr Eggleston I think the plan is in essence, a very satisfactory one I would raise one or two questions regarding the maintenance of "dry weight," or first as to the securing of a "dry weight." It has been my habit to come as close as I could to the 'dry weight' by the use of a regimen, not radically different from the one just discussed, but there are patients who experience a great deal of discomfort when they are reduced to the "dry weight." They complain rather bitterly of muscular pains and aches, or even of cramps and altogether they are pretty nearly

as uncomfortable at times as they were in the milder stages of their congestive heart failure I, therefore, question whether this regimen can be applied as successfully to all patients without considerable individual judgment as to modification from time to time with a little relaxation here, a little change there, in the plan of therapy. Of course, in essence the plan of therapy is presumptively correct, and I agree with the general thought behind it

I would like to ask Dr Gold what average doses of the mercurial he finds necessary, and whether he administers it intramuscularly or intrave-Does he make a choice between the two methods? His initial diet is, of course, only a slight modification of the Karell diet, which was essentially a salt-free diet It consists of 800 cc of milk per twenty-four hours Dr Gold raises that to a little higher level of milk and adds two quarts of water I think those of you who are not too familiar with the situation should recognize the fact that it is not the water but the sodium in the diet which counts in the retention of fluid in the tissues

I don't think this is the place to quibble over what is the correct therapeutic dose of digitovin The scheme of 1 2 mg as the initial dose, followed by 0.2 mg daily, works perfectly satisfactorily in a very large majority of the patients, but there are patients, small though the numbers may be, who will develop signs of digitalis intoxication on this regimen and the dose, therefore, will have to be adjusted to meet their needs You should remember that digitovin is retained long in the body and continues its action for a long period of time so that, while it is the most desirable agent for general therapy in the digitalis field, you cannot backtrack quite as quickly as you can with some of the more rapidly eliminated glycosides of the digitalis series

DR CATTELL There is one question I would like to ask Dr Gold, namely, whether you anticipate continuing the mercurial indefinitely in these cases after the congestive failure is relieved?

DR GOLD In answer to Dr Cattell, we do anticipate continuing the mercurial indefinitely. There are some in whom it may be discontinued after a time. There are others who continue to require a daily dose for the remainder of their lives. The system provides appropriate means for deciding how long the mercurial will be continued. The objective is always kept in mind, namely, to establish the "dry weight," and then, to maintain the "dry weight". After the "dry weight" has been established by the daily dose of the mercurial, the interval between doses is prolonged. In that process of gradually prolonging the interval we discover those cases who do not show a tendency to become "wet" even when months or

years clapse after the last injection of the mercurial, in the same way we also discover those who tend to become "wet" when the interval is only twenty-four hours, between these two extremes he the large numbers of patients in whom the permanent maintenance dose of the mercurial is necessary at any one of a wide variety of intervals, determined for each case individually

In regard to the discomfort resulting from the "dry weight." Dr Eggleston, I should mention again our definition of the "dry weight" It is that state in which the optimum amount of extricellular fluid remains in the body Such a state does not produce discomforts Perhaps a more satisfactory term would be "optimum weight" rather than "dry weight" The reason we have avoided the term "optimum weight" is the fact that it is difficult to define a method for arriving When the system is started, the patient begins to lose weight and, after several days to a week or two, in which the mercurial injection is given daily, the losing of weight comes to a fairly This is a sharp endpoint abrupt end majority of patients feel at their best when this point is reached, a few show undue weakness, muscular cramps, and other unpleasant symptoms which indicate excessive dehydration them to gain a pound or two and they feel better at this higher level We have observed that the production of unpleasant symptoms during the course of dehydration quite frequently is related to the speed with which it is carried out In general, the system should so be adjusted as to avoid a loss of more than 2 or 3 pounds per day, although I am sure that you have observed many patients in whom a loss of 5 pounds or more per dry was tolerated without discomfort to regulate the speed of dehydration, and thereby control unpleasant reactions, by adjusting the daily dose of the mercurial Obviously, the smaller the dose the smaller the diuretic effect

As to your question concerning the dose of the mercurial, we usually start with 0.5 cc mercuhydrin. If this causes no unpleasant reactions due to allergy or to excessive weight loss, and the diuresis is adequate, a weight loss of 2 or 3 pounds, we continue that dose daily. If the diuresis is inadequate, we increase the dose to 1 cc or 2 cc daily in the endeavor to secure a continuous weight loss of 2 or 3 pounds a day. In a few cases we have had to increase the dose to 2 cc every twelve hours in order to establish adequate diuresis. The system is sufficiently flexible to take care of the major varieties of unusual sensitivity or tolerance to the drug

Our routine plan calls for the intramuscular injection If, for some reason, that method is not feasible, we give it intravenously It is safer by intramuscular injection

You are quite right in your statement that our diet is essentially a Karell diet. Perhaps I should distinguish the important from the unimportant ameets of it It rarely matters whether the pa tient receives 800 cc of milk or 1 000, or even The point of importance is that 1 500 cc. a day such a diet insures against the patient receiving more than from 1 to 1.5 Gm. salt per day is the simplest form of a light diet to achieve that end and it makes the least demands on the dietary service of the hospital It is also the least trou blesome in the home I should not be so much concerned with the problem of making things easy for those who look after the patient with con gestive failure, if it were not for the fact that lapses are so frequent when diets more trou blesome to arrange are prescribed The so-called low-salt diets of hospitals contain from 3 to 6 Gm of salt, and not infrequently, the salteellar appears on the tray by mustake. Such diets are also relatively inflexible, if the salt content turns out to be too high as seen by the failure of the patient to respond satisfactorily it is often extremely difficult to have it properly rearranged course, if the patient shows some form of intol erance to milk there is no choice but to arrange a different type of dict containing from 1 to 1.5 Gm. of salt We might bear in mind the fact that it is rarely necessary to continue such a low-salt diet as is represented by the milk alone for more than about a week, and most patients will cooperate satisfactorily for this relatively brief period of time

Dr Egglesten, you stated that you use essentially the same kind of system Do you give the mercural diuretic every day?

Dr. Egginstov I do use the mercurials daily where necessary and have done so for a consider able time. I have never seen any detriment to the patient from their use in this way

Dr. Gold I am glad to hear you say that I would only point out that our system calls for the routine use of the daily dose of the mercurial to abolish the attack of congestive failure rather than in some special cases as implied by your term "where necessary" It is our view that in every case of congestive failure dehydration is an esential feature of the therapy, and that this should be carned out with the greatest expedition consistent with safety and comfort. We have taken the position that, even though complete reversal of the state of congestive failure is possible, in many cases with digitalis alone, or with digi talm together with salt restriction and the dose of the mercural every third or fourth day it takes unnecessarily long to accomplish the results, and that the daily administration of the mercurial in every one of these cases results in a curtailment of the period of disability Accelerating the speed of recovery without adding discomforts or dangers can be advantageous only

DR EGGLESTON May I add that I spoke of the discomfort of the patient during the use of the mercurial for the purpose of making you discuss it a little more because it is a very real factor and can become very troublesome unless one is can tious in guiding the course of dehydration of the nationt

DR CATTELL Dr Stewart, would you care to comment at this point?

DR HAROLD J STEWART I think the daily use of the mercurial is about the only thing new in this regimen which Dr Gold has described Everybody I think, who has been taking care of patients with heart failure, has been weighing them every day, so that is not a new procedure. Some have been using small amounts of fluid. others, large amounts. Many have been using The only new point is that he advocates the use of daily injections of the mercurial have not been able to get nationts free of heart failure with the use of unlimited amounts of fluid as has been recommended by Schemm placed a series of patients on an accurately con trolled low-salt intake and forced fluids in none were we able to abolish the heart failure even when we added the mercurials. For the most part I still use limited fluids and a low-salt intake

I wonder whether Dr Eggleston's experience with digitorin has changed since last year think I remember his saving at a conference last year that he used more than 1.2 mg of digitalin Nativelle to digitalize patients adequately

I said that most of the pa Dr Eggleston tients required more than that for full digitali

DR. STEWART In our experience, it has taken from 1 5 to 20 mg

DR. CATTELL In one dose?

DR. STEWART We gave it to a few patients in a single dose but we don't advocate that.

DR CATTELL Dr Gold you have had some ex perience with the single dose of 2.0 mg happens?

DR GOLD It is much too large for routine single dose digitalization We gave 20 mg of digitalin Nativelle at one time to a group of patients and about one third of them developed toxic effects.

DR. CATTELL Have you any further remarks on Dr Stewart a comments?

DR. GOLD I agree with Dr Stewart s view that the individual items involved in our plan of treatment of congestive failure are not new Water milk, salt restriction, digitalis, mercurial diu retics, and weighing of the patient have all been used by others. I must confess that I know of no writings other than our own advocating the rou-

the mercurial diuretics in ambulant patients with heart failure is at least as important as the continued use of digitalis. In the case of digitalis, we continue a daily dose indefinitely case of the mercurial diuretic, a large proportion of patients also need it indefinitely. Only a few require it daily In the majority, longer intervals The interval is determined in every case by first reducing the patient to the "dry weight" by daily doses, and then finding the longest interval between injections which enables him to maintain the "dry weight" The arbitrary maintenance plans of two injections a week or one in two weeks, or an injection when symptoms return, are deplorable

DR CATTELL Do you consider that the continual use of the mercurial diuretic actually prevents the patient from going into congestive failure?

DR GOLD That is precisely the case The size of the doses and the intervals between them are correct when they maintain such a urine flow as to prevent any conspicuous fluctuations in the body weight The maintenance interval is too long if the injection makes the patient lose a few pounds In that event, the interval should be shortened so that the patient loses almost no weight on the day of the injection The chief mechanism in the clinical state of congestive failure is a disorder of salt and water metabolism leading to tissue hyperhydration A plan of therapy which provides continuous dehydration keeps these patients free of the signs and symptoms of congestive failure

DR MODELL I should like to ask Dr Gold what he means by congestive failure Does he apply this regimen only to patients who show one or more of such signs as pitting edema of the extremities, enlarged liver, pulmonary rales, ascites, or hydrothora?

DR GOLD We do not have an entirely satisfactory definition of congestive failure tempt at a definition may be made either in clinical terms or in terms of mechanism pear to be a number of mechanisms involved. such as diminished contractile power of the heart, high venous pressure, increased blood volume, a disturbance in salt and water metabolism, and The factor which seems to be present in practically all cases is the retention of salt and I find it most useful to formulate congestive failure as a clinical state involving a disturbance in salt and water metabolism leading to tissue hyperhydration, occurring most commonly in chronic heart disease, and resulting usually from a chronic circulatory disorder in the pulmonary or systemic circuit It is most important to bear in mind that increased wetness of the tissues occurs long before the appearance of the signs

Accordingly, a patient which you mentioned may have congestive failure without pitting of the extremities, or enlarged liver, or pulmonary rales, or ascites, or hydrotho-Shortness of breath is an important symptom of congestive failure. It may be present without any of the other demonstrable signs of increased wetness of the tissues In fact, some of the most severe and disabling instances of congestive failure involve only shortness of breath as evidence of congestive failure We should remember that interstitial edema of the lungs may not give rise to any rales yet such patients may he completely incapacitated by dyspnea or or-The system of dehydration which we have outlined provides such patients with complete relief I might call your attention to a most striking case of that kind which we encountered recently The patient had hypertensive and arteriosclerotic heart disease with a massive heart and a gallop rhythm complaint was shortness of breath This had progressed to a point at which he was unable to be down because of the extreme orthopnea and Cheyne-Stokes' respiration He had been receiving oxygen, digitalis, intravenous aminophylline, and restricted fluids Since there were none of the frank signs of edema, no rales, no enlargement of the liver, and no edema of the legs, the mercurial diuretics had been withheld went from bad to worse, and at the time we saw him, it looked as if he would hardly survive the He was promptly placed on the regimen of treatment which we have already outlined, a daily dose of the mercurial, six glasses of milk daily as the sole diet, and 3,000 to 4,000 cc of He lost 14 pounds in four days, and on the seventh day was discharged from the hospital almost completely free of symptoms Here was at least 14 pounds of extra fluid which failed to produce any of the standard signs of edema It was found necessary in this case to use a dose of the mercurial every other day for maintenance Several months later, he was still up and about, working, and substantially free of symptoms

There are other cases in which the presenting symptom of congestive failure is cardiac pain. Some patients who are troubled with the angina decibutus, attacks of cardiac pain appearing usually at night, awakening them after they have been asleep a few hours, are completely relieved by the system of dehydration which we have described. This also applies to patients who show none of the standard signs of edema, and are able to carry on fairly active work during the day, but are subject to attacks of pulmonary edema at night. The application of the regimen which we have described to establish their "dry weight" and to maintain the "dry weight" by suitable ad-

justment in the regimen, renders them free of at-

DR. STEWART In our cardiac clinic we have many patients who come in one, two, or three times a week for their mercurial injections, as required for each patient to maintain freedom from heart failure as estimated by their physical signs and change in weight. Some of them have been on such a regimen for seven or eight years, or longer. I had not realized that weighing patients was not a common practice in taking care of them as it is in our clinic at the New York Hospital.

Dr. Eggleston I don't think that weighing the patients is a common or a prevident practice, but it is certainly a custom in our clinic, and they do very well.

I would like to ask Dr Gold how much difficulty he encounters in bringing these patients under control when they refuse hospitalization

der control when they refuse hospitalization DR. GOLD Sometimes a great deal of difficulty, other times very little This system is perfectly easy to carry out at home You do not need a doctor for the injections Let the patient stay home and rest in a chair Let him take four to six glasses of milk daily and a glass of water every two to three hours Have a nurse administer the intramuscular injection of the mercurial It might be well to explore the thighs and arms for suitable places for relatively painless injections If a nurse is not available the patient or a mem ber of the family may be taught to make the injections The problem is similar to that of in sulin and diet in diabetes There the patient is instructed in matters of diet, injections and exammination of the urine. We would never have achieved the successful treatment of diabetes if a physician or nurse or hospital were necessary for the treatment. The same is true of congestive The successful control of congestive failure requires that the patient or a member of the family be instructed in the arrangement of low-salt diet, in the technic of the mercural in jections, and in the keeping of a chart of the daily weight But before that can be accomplished, physicians must begin to think in these terms.

Dn. Stewart Dr Gold I was not aware that doctors taking care of patients with heart failure did not discuss with the patient or a member of his family how to prepare a salt poor or salt-free diet maintenance of body weight etc. This has long been my own practice and the custom in our clinic

Dr. Eggleston Dr Gold do you trust the home scales?

Dr. Gold No Have them procure a new one The greatest trouble is with the hospital scales They are often so inaccurate and so inaccessible and to procure a new one in the bospital is not ways so simple a matter I should like to say a word about a point which Dr Pardee raised, namely, the duration of the treatment with the milk diet. It is not long In a recent study of ours on 140 admissions for advanced congestive failure, the average time from the day of admission to the achievement of the 'dry weight' was approximately six days. In a series of 502 admissions of similar cases in four large hospitals of New York City treated by other methods in current use the average time required to achieve the same results was approximately fifteen days.

I may also say a word about Dr Stewart's comment to the effect that it is common practice for the patients in his clinic to receive one or two injections of the mercurial a week. It may be that these patients are doing as well as is possible but from the experiences in our clinics with a rela tayely fixed system of mercurial injections I would suspect that many of them are being main tained as partial cripples always on the border of congestive failure less dysphere on the first day or two after the injection than on the day before the next injection. That is not satisfactory maintenance. The best results require an initial penod of treatment in which the weight is reduced to the "dry level" by the daily dose of the mer curial in addition to the other elements of the regimen which we have described followed by a period of adjustment in the regimen so as to discover the most liberal diet and the longest inter val between injections which suffices to maintain the 'dry weight" The maintenance plan will differ from case to case one patient requiring an injection every day, and another being able to maintain a 'dry weight" with an injection once a week, or once in 2 weeks, or even longer course, thus is very difficult to do in the way in which the average outpatient department is That is why I urge that the patient operated be instructed in the technics of this treatment to make him independent of a visit to the clinic for most of the injections Again, the problem of treating congestive failure is essentially the same as that of diabetes.

DR. CATTELL Dr Leiter of the Monteflore Hospital is here today He has been engaged in the study of the problems of congestive failure We all would appreciate a few comments from him.

Dr. Louis Leiter At the Montefiore Hospital we deal largely with chronic congestive failure I think we all agree that Dr. Gold's system is perfectly satisfactory in its general principles for the management of congestive failure in the acute phase. It is easy to obtain the patient's cooperation at this time. The patient is very ill he is exaping for breath, and he has little desure for Little difficulty is encountered in

such a patient on a diet of milk The real difficulty, however, as Dr Gold and others have intimated, arises when the patient becomes convalescent and faces the problem of continued invalidism in the form of chronic congestive failure Now the matter of an adequate diet which the prtient is willing to continue to take becomes a problem of paramount importance We question the use of the milk diet by itself at the beginning because in the next ten or fifteen years of the patient's life, we shall have to be struggling with suitable diets which contain little or no milk Might it not be wiser to begin treatment with mixed and adequate diets low in sodium rather than with milk alone? The injection of three or more doses of the mercurial a week, furthermore, is a very troublesome business. It is all very well when the physician can go to the prtient's home or when a competent nurse can be used for the It is quite another matter in a large clinic to which patients may have to come in the There is the considerable physical evertion and the difficulty of transportation

As we looked into the matter, we found that the poor results obtained by patients even in the hands of very competent physicians who made use of digitalis, the mercurials, and other items of treatment were due chiefly to improper diet. The liberal diet seemed to be the chief reason for the frequent readmissions to our hospital. We found that by means of a diet containing only 1 or 1 5 or 2 Gm. of salt, usually less than 1 Gm of sodium, these patients could be maintained satisfactorily. Most of them reach a point at which they require a mercurial injection only once in two to four weeks.

two to four weeks The reason for this situation is simple The patient with congestive heart failure has a glomerular filtration rate well below the normal, but good tubular reabsorption of salt Therefore, if his diet contains 4 or 5 Gm. of salt daily, and he excretes only 2 Gm because of his reduced filtration rate, it is obvious that he will put on a kilogram of edema fluid every three days fore, would require one or two mercurial injections a week to be comfortable I should like to place the greatest emphasis on the matter of training patients to use the proper diet course, there still remain the cases with cardiac cirrhosis and ascites, and those with pleural and pericardial effusions, who may need more frequent injections of the mercurials or may need to be tapped from time to time There also remain the cases of severe undernutration, which present special problems One of the greatest problems in the management of chronic congestive failure is the prevention of undernutrition for one, do not believe in allowing a patient a diet

fairly liberal in salt, and then controlling the con-

gestive failure by several doses of the mercunal a week. I do not believe it is a satisfactory means of preventing what eventually will become a state of severe undernutration. We see many patients with congestive failure whose undernutration as the result of cardiac management is as severe as any encountered in the concentration camps.

At this point, I would like to ask Dr Gold how he can tell, in connection with the establishment of the "dry weight," whether a slow decline in the base-line of the weight is due to loss of cellular fluid or to undernutration Dr Stewart I wonder if Dr Deitrick is here

to say something about the ill effects of the duly dose of the mercurials

DR CAPTELL Unfortunately, Dr Deitrick is not here. We were discussing the matter of the

dangers of the mercurials yesterday We brought up the attitude of some of the people in New Haven where the mercurials are considered only as a last resort in the treatment of congestive failure on account of the risk of renal injury. I am afruid we will not have time for much more general discussion

DR NATHANIEL T KWIT Would Dr Gold

comment on the importance of making sure that the patient does not consume sodium in the form of medications which might be prescribed? DR GOLD That is an important point Attention has been called by several writers

to the need for insuring that the patient

does not receive the rhubarb and soda mixture, or other sodium containing antacids for indigestion, or large doses of sodium bromide for sedition Not so long ago we were engaged here at this hospital in the treatment of a rheumatic patient with advanced congestive failure, who failed to respond and whose congestion continued to in-We then discovered that the patient had received about 50 Gm of sodium bicarbonate in the form of Sippy tablets during a period of about eleven days in which the course was progressively The congestive failure cleared drimatically as soon as these were discontinued and the proper regimen involving milk, abundant water, and daily doses of the mercural was instituted DR MODELL Dr Gold, you stated that by

DR MODELL Dr Gold, you stated that by the method of treatment of congestive failure, which you outlined, you achieve the "dry weight" in an average of six days, while it takes about fifteen days to produce the same results in similar cases with the methods in current use. Is that the only advantage of the method, the saving of some days? Why the hurry, since these are pretty ill patients and are likely to have to be laid up for some time even after they reach their "dry weight?"

Dr. Gold There are, in fact, other advantages besides the saving of time. The regimen I descaled resulted in complete disappearance of congetive failure in 90 per cent of the group of 140 almissions treated in that way, as against only about 50 per cent of the 502 admissions of similar cases treated by the methods in current use which involve mixed so-called low-ealt hospital diets water restriction, orni diuretics occasional doses of the mercurial at infrequent intervals and with out the use of the weight chart as a guide these methods of treatment, about one third of the patients are discharged from the hospital with only moderate relief of the congestive failure This type of result has practically vanished in the treatment by the regimen which I described To this new regimen, there are a few advanced cases of congestive failure who show no response or at most a negligible one, while in the remainder the relief of the signs and symptoms of congestive failure is complete. The new regimen should also eliminate the largest proportion of cases of readmission for congestive failure thermore, I do not believe one can minimize the importance of the time factor alone the reduction of the period of complete disability in congestive failure to nearly one third of the usual period. A very strong case has been made out in rerent years for the advantages of early ambu lation There is little doubt that the curtailment of the complete rest period from an average of fifteen days to six days will show itself up in the form of a reduced meidence of venous thrombosus in the legs and pulmonary embolus sider also the diminished burden on the nursing staff Some of us might be interested in the economic aspect on the basis of about 1 000 000 patients suffering with congestive failure in the United States, the new regimen involves a poten tial saving of about \$50 000 000 per year in hospital care

Dr. Catrett. Dr Gold would you close the decusion\*

Dr. Gold With respect to renal damage I am quite certain that the risk is negligible with the doses used in this regimen. Sometimes the blood NPV ries. The mechanism of the rise is in need of further study. The important point is that it appears to be a completely revisible action in much the same way as the therapeutic action on the renal tubules to impair the realisorption of sodium. There are many unpleasant symptoms which result from arcessive loss of base and excessive dehydration but there is very little excuse for these because it is merely a matter of dosage of the mercural and with proper adjustment of the dose, these effects should occur rarely.

As to your question Dr Leiter, regarding the

matter of distinguishing a falling weight-curve due to undemutrition from one due to loss of fluid I would say that we have encountered that rarely. The problem which we encounter quite frequently is the reverse namely, that of distinguishing a rising weight-curve due to good body tissue from that due to accumulating edema fluid. We resolve that easily by a few extra daily doses of the mercurial during the maintenance period if these cause an abrupt fall in the weight-curve it is clearly an increase of edema fluid and not good body, weight

I do not believe there is any escential dwagreement between Dr Leiter's view and our own regarding the management of congestive failure He emphasizes the aspect of low-salt diet as a means of maintaining the dry weight and we place more emphasis on the use of the organic Neither of us it seems to me neglects either of the factors I know that the I to 15 L. of milk daily is not an adequate diet but then we use that diet for only a period of a week or Our muntenance diet is a mixed one and adequate from the standpoint of vitamins types of foods and calones. Our regimen therefore rarely gives use to a state of undernutration except in so far as the advanced disease with disturbed liver function makes it impossible for the patient to maintain a satisfactory nutritional state regardless of the food that is given

I gather Dr. Leiter pursues the practice of providing the patients with a high coloris diet con taining only 1 to 1 5 Gm. of salt during the years of maintenance and in that way finds it possible to keep the patient 'dry with only an occasional dose of the mercural diurotic We have several diets representing about 2 000 calones and only about 1 Gm. or less of salt The list looks quite impressive but the food is anything but pala Some patients, during the long period of maintenance prefer that diet together with an in frequent dose of the mercurial but others prefer a more palatable diet containing more salt, even if it entails the more frequent use of the mercural It seems to me chiefly a question of the patient s preference and the ease with which the 'dry weight can be maintained by one or the other I doubt that we have any evidence for a choice between the two from the standpoint of the patient's nutritional state as long as we are able to maintain the patient in the dry' state with either method I think that there is here also an analogy between diabetes and congestive Is it better to maintain the diabetic putient on a highly restricted diet with little or no insulin or on a more liberal diet with more in sulin? A similar question may be asked in relation to congestive failure. Is it better to maintain the patient in the dry state with a

highly restricted diet containing only 1 to 15 Gm of salt, using only an occasional dose of the mercurial, or with a more liberal and more palatable diet, using a more frequent dose of the mercurial? We prefer the latter

## Summary

DR GOLD In the conference this afternoon a new regimen was described for the treatment of It involves no new principles congestive failure and no new drugs It is essentially a new design for putting the well-known factors into a highly effective system for routine use It provides not only for abolishing the signs and symptoms of congestive failure with the greatest expedition and in the largest number, but also for the maintenance of the gains and the prevention of recur-It is applicable not only to patients with advanced failure with pitting edema, enlarged liver, pulmonary rales, and effusions, but also to the large group of ambulant cardiac patients with only shortness of breath on exertion, orthopnea, attacks of cardiac asthma or cardiac pain, or attacks of pulmonary edema The regimen may be applied conveniently both in the hospital and in the home It requires a minimum of nursing and medical supervision

Dehydration is the primary factor in this system of treatment. There are five cardinal ele-

ments involving the simultaneous use of digretoxin, the mercurial diuretic, salt restriction, abundant water, and the guiding of the course by a chart of the patient's daily weight, which must be followed in this system. The maintenance plan consists of the same elements, adjusted to meet the requirements of the individual patient.

Emphasis was placed on the use of a daily dose of the mercurial to bring an attack of congestive failure under control, and on the maintenance dose of the mercurial at suitable intervals in order to prevent the recurrence of congestive failure. The use of a chart of the daily weight was stressed as in essential guide to the proper care of the patient with congestive failure. Attention was called to the similarity between the problem of treatment of diabetes with diet, injections of insulin, and urine examinations, and the problem of treatment of congestive failure with diet, injections of the mercurial diuretic, and a chart of the daily weight as a guide.

The most interesting feature of the conference lies in the searching questions concerning the proposed regimen raised by members of the audience expert in the management of heart disease. These provided an opportunity to explore the mechanism of congestive failure, and the reasons for the various factors in the proposed regimen of treatment.

#### THE VERMIN-KILLER

- Just

Many interesting and unusual ideas may be learned from the perusal of THE VERMIN-KILLER Being a complete and necessary Family-Book, published in London in the eighteenth century. This little book, in the collection of the History of Medicine Division, tells the reader such things as how to kill fleas, how to buy a horse, the best cure for colic, and rules to "judge the weather"

The following are a few choice items

"Recipe for the Bite of a mad Dog, taken out of Cathorp Church in Lincolnshire, in which it was solemnly recorded for the perpetual Memory of the Thing, that the whole Town almost being bitten, not one Person miscarried, but was cured, who took this Method

"Take the Leaves of Rue pick'd from the Stalks, and bruised, six ounces, Garlick pick'd from the

Stalks and bruised, Venice-Treacle or Mithridate, and Scrapings of Pewter, of each four Ounces, boil all these over a slow Fire in two Quarts of Ale till one Pint is consumed, keep it in a Bottle close stopped, and give of it nine Spoonfuls warm to the Person seven Mornings successively, and six to a Dog , apply some of the Ingredients to the Part bitten

"I'ov

"Anoint the Soals of Fat a little broiled." here and there in Honey, draw follow you, so Medical Libr

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#### ABSTRACT OF MINUTES OF THE COUNCIL OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

AT ITS meeting on November 13 1947 the Council considered various matters, taking final action or directing further study and reports as indicated under the following headings

#### Secretary's Report

Remission of State Assessments -- Remission of State assessments was voted on account of service with the armed forces for 3 members for 1947 and 9 for 1946, also on account of illness for Drs. Henry Almour William Murray Ennis and George Lowes

Hagman

Mertings—I our Secretary has attended four District Branch meetings at Norwich, Liberty, Garden City and the Bronx, since the last Council meeting On October 20 with Dr Robert R Hannon I represented the Society in Albany, at a subble bearing of the atmospher Rights commission to public hearing of the temporary State commission to study the question of establishing a New York State University After conferring with Dr Hannon and other members of the Society I presented the point of view that there is no need of another medical college in New York State at this time Rappleye Wenkotten, and McFwen also testified

On October 24, I attended a hearing of the New lork City Health Department regarding the use of

fluoroscopes by shot salesmen

The annual meeting of County Medical Secre-tance was held at the Hotel Ten Evek Albany, Wednesday November 5 It was well attended and the program seemed to evince interest night your Secretary went to Chicago when he attended the American Medical Association con ference regarding civilian medical services for voterans service-connected desabilities Dr Herbert

H Bauckus also represented Veterans Viducal Service Plan of New York, Inc., at this meeting On November 7 and 8, in Chicago your Secretary attended the annual Conference of State Secretaries and Editors where I had the honor of acting as moderator at a panel ducussion regarding federal

and state legulation.

It has also been my privilege to answer correspondence and attend Committee meetings

Deaths.—It is with sadness that I report to you the death of Dr Frederic E Sondern, past president of the Medical Society of the State of New York on October 10, 1947 With the approval of Dr. Bauer notices of Dr Sondern a death were inserted for the Soriety in the New York Herald Tribune Times, Sun and World Telegram I also sont a telegram of sympathy in the name of the Society to Mrs. Son dern and dispatched flowers to the funeral which I attended on October 13

On October 15 a telegram of sympathy was sent to Mrs Alfred I Madden past preadent of the Woman's Auxiliary of the Medical Society of the State of New York, because her husband had ded

\*uddenly

Nominations to Nurse Admsory Council of New 1 ork State Education Department - Miss Clara Quereau, secretary Board of Examiners of Nurses, has requested two nominations from this Council for membership on the Nurse Advisory Council of the New York State Education Department, because Dr Norman S Moore a membership will terminate at the end of this year Dr Moore has signified his will need to be a like the willingness to accept a renomination I take the liberty of suggesting that you advance the name of

Dr W Guernsey Frey, Jr as an additional candi date for the Board of Regents to consider

It was roled that the Council recommend to the Board of Regents, for membership on Nurso Advisory Council of the New York State Education Department, the names of Dr Norman S Moore

and Dr W Guernsey Frey, Jr Appointment to New York State High School Athletic Protection Plan, Inc.—Dr Herbert L. Bauckus has been a member of the board of directors of this Plan for several years and he would like to be

replaced

The Council roted to recommend to Dr. Bauckus that he suggest the name of Dr Kenneth Horton Rockville Centre Long Island as his successor Representations from Adjoining States to Annual

Meeting

It was roted to invite representatives of the Medical Societies of the states of New Jersey Pennsyl vania, Connecti ut, and Vermont to our Annual Meeting

Communications -1 Letter from Dr Joseph J Witt 258 Genesce Street Utien, New York, dated November 4, 1947 requesting proposal to the Council that they recommend to the House of Delegates that the Session on Chest Diseases be

changed to a Section on Chest Diseases

After discussion at was roted that the Council in its annual report to the House of Delegates

will so recommend

Letter from California Medical Association and resolution adopted by their Council on Septem ber 21 1947 regarding blood banks

After discussion it was roted to refer this to the Committee on Public Health and Education Dr. O W II Mitchell chairman for recommendation

Letter from the Namau County Medical Socoty dated October 10 1947 requesting that Doctor Hobart S Van Nostrand be permitted to remain a member in the Nassau County Society although his office and residence are one block inside the Queens County line

After discussion, it was roted that Dr Van Nostrand's request be granted as permitted by

the Bylaws.

4 Letter from Dr Malcolm Buchanan, 115 Winthrop Street, Watertown New York, dated October 14 1947 requesting a life memberahip button from the Medical Society of the State of New York for retired members

It was roted to refer this to the Bureau of

Public Relations

o Letter from Kings County Medical Society, dated October 16 1947 requesting clarification of questions relating to membership

After discussion it was roted that Kings County he advised that each such question should be

referred to the Council for consideration

Letter from Dr B Wallace Hamilton secretary of the Modical Society of the County of New York under date of October 21, 1947 submitting a resolution passed by the New York County Society which advocates establishing a special type of membership in the American Medical Association

After discussion at was roted that the Medical Society of the County of New 1 ork be informed that their delegates may introduce such a resolu-tion in the House of Delegates of the Medical bociety of the State of New York next May

Treasurer's Report was accepted

### Report of Executive Officer

Hannon reported verbally that the last district meeting was held October 30 He also attended the public hearing, mentioned by the Secretary, as to the need of a University of the State of New York, in Albany on October 20

The Executive Officer, with Dr Maurice J Dattelbaum, chairman of the Committee on Cults, visited the First Institute of Podiatry, interviewed its president and some members of the staff and in-

spected the institution

On November 5 the Secretaries' Conference was

hold in Albany

A meeting of the Legislative Committee was held in New York on November 12, to plan for legisla-

#### Activities of Committees

Constitution and Bylaws -Dr James R Reuling, chairman, reported that the Medical Society of the County of Albany requested approval of a change in their Bylans This approval was voted

Convention —Dr Harry Aranow, chairman, reported that there had be n a meeting of the Committee and that most of the annual meeting programs of sections and sessions have been prepared

Economics —The following report of the Director of the Bureau of Medical Care Insurance was sub-

mitted

October 7, 1947 Mr Farrell conferred with Dr Aaron, chairman of the Subcommittee on Medical Care Insurance, in Buffalo, to discuss the Committee's program for the coming year. The projects

contemplated were

Survey of doctors and members in each plan area by personal interview, to determine physician and member reactions to the plans, letters to be sent in advance of each interview The Chairman feels information so obtained will be helpful in clarifying misunderstandings which now exist between doctors and the plans and will improve public relations. In addition the Bureau will be able to evaluate the type of contract moet suitable on a state-wide basis

Survey of county medical societics which have not given approval to their local medical care plan, the Bureau to offer its services to correct misconceptions and obtain possible

Contact each county medical society which has an official publication, to ascertain if space would be given for information about the medical care plan operating in its area, material to clear

through the Bureau

Develop periodically an informative folder showing progress of plans throughout the State to be distributed to members of the Society, the cost to be met by each plan in proportion to the num-

ber of folders required
October 9, 1947 Mr Farrell met Dr Leon M Roe
and Dr Arthur J Karl, members of a special committee of Steuben County Medical Society, in Canisteo, to consider affiliation in a medical care As a result of this conference, recommendations will be presented at the next meeting of the Steuben County Medical Society Mr Farrell has offered to appear at this meeting, if requested

The Director of the Bureau attended the following District Branch meetings October 16, Third District at Ferndale, October 29, Second District at Garden City, and October 30, First District at the Veterans Administration Hospital, New York City

At the Fourth District Branch meeting at Amster-im Mr Farrell presented a paper on "Piesent

Status and Future of Medical Care Insurance in New York State "

Mr Farrell attended the annual conference of Secretaries of County Medical Societies in Albany, November 5, 1947

Ethics —Dr Reuling, chairman, reported he had received a letter from Dr Fred H Voss, secretar, of the Medical Society of the County of Ulster, re questing a ruling on carrying box advertisements in the local papers

After discussion, it was voted that it is unethical

to print box advertisements

Finance Committee -Dr Albert F R Andresen, chairman, presented the proposed tentative budget for the year 1948

After discussion, it was voted that the budget be referred to the Board of Trustees for preliminary consideration, and that final action of the Coun cıl be taken in December

Public Health and Education -Dr O W 11

Mitchell, chairman, reported as follows

October 18, 1947 In New York City attended a
meeting of Convention Committee

October 21, 1947 In New York City a meeting of
the Council Committee on Public Health and Education and the Subcommittees on Maternal and Child Welfare was held. In addition to members of these committees, officers of the Medical Society of the State of New York and representatives of the New York State Department of Health were present

November 5, 1947 Chairman addressed the ion ference of Secretaries of County Medical Societies in Albany regarding activities of the Council Committee on Public Health and Education

November 12, 1947 Chairman attended the meeting of the Subcommittee on Cults held in New York

City

November 12, 1947 In New York City a meeting of the Council Committee on Public Health and Education and the subcommittee on Child Welfare was held for the further discussion of pediatric con sultation services and the proposed regulation for the control of diarrhea in prematures. Some of the officers of the Medical Society of the State of New York and representatives of the State Department of Health were present

Subcommittee on 4-H Clubs and Youth Health Activities—Dr J G Fred Hiss, chairman, reports "On October 14, 1947, your Chairman attended a meeting of the New York State 4-II Health Committee of the New York State 4-II Health Committee of the New York State 4-II Health Committee of the Mental New York State 4-II Health Committee of the Mental New York State 4-II Health Committee of the Mental New York State 4-II Health Committee of the Mental New York State 4-II Health Committee of the Mental New York State 4-II Health Committee of the New York State A-II Health Committee of the New York St Committee in Syracusc Among the important things discussed were, first that the 4-H clubs might be used to aid student nurse recruitment, second, aid in fire-prevention week, third, promote bicycle safety, and fourth, be instructed in tructor maintenance, including safety Matters discussed at the meeting dealt chiefly with increas-About the same num ing farm and home safety ber of clubs entered the health contest this year as m 1946 The number of clubs entering this is still far less than one-half of the clubs in the

"The great need of having a health educator attached to the 4-H health office was again stressed and a formal request was forwarded to the proper authorities It is my own personal opinion that the health program will lag in this organization until such time when a full-time health educator will be available for this purpose"

Postgraduate Education —In addition to the in struction mentioned in the report of the Committee on September 30, 1947, instruction will be given in the near future in Dutchess, Madison, Monroe, Nassau, St I awrence and Steuben counties

Arrangements are being completed for a Regional Industrial Health Teaching Day in Troy on Thursday, December 11, 1947 Announcements will be mailed to the members of the following county medical societies. Alban, Columbia, Rensselaer, Saratoga and Washington

Instruction has been completed in Oncida Schoharie Seneca, Suffolk, and Wayne counties

Cancer—Dr Anderton presented the following report for Dr Mitchell chairman

A meeting of the Subcommittee on Cancer of the State Society Committee on Public Health and Education was held at the Roosevelt Hotel on October 17 1947 The meeting was called by Dr Mitchell Also present were Drs Adair Adie, Bacht Fitzgerald Jacobsen Lovin Perkins, Ran dall Sine By invitation the following attended Drs. Anderton Hannon, Redway, and Wetherell

Cancer Teaching in Medical Schools 'A discussion was held, headed by Dr Adair, relative to teaching about cancer to medical students. A plan favored by Dr Adair was presented in detail. It was the opinion of the Committee that a method of teaching which correlates the entire field of cancer should be adopted by medical schools in New York State. However before making a definite recommendation the Committee felt that an accurate knowledge of present cancer teaching throughout the State should be made available to it and that care should be exercised not to divorce cancer diagnosis entirely from other allied conditions. The committee strongly felt that cancer teaching should be as thorough and as practical as possible at the student level, and not be deferred until the period of postgraduate study "The Committee felt that it was within the

province of the State Society to encourage such a plan The Committee scales the advice of the Council regarding further pursuit of this matter

During the past 15 years there have been established, in various parts of the State, tumor clinics which have become a real asset to the community These are now accepted by the public and the profession They have become an im portant part of the cancer diagnosis and treat-ment program Inasmuch as these clinics offer a definite contribution, the Committee believes that the tumor clinic attention in the State should be reviewed the purpose being to survey existing clinics as to equipment and personnel. It is possible that additional equipment may be needed and that clinic physicians might desire further training by means of short term courses. At the present time detection centers and research have crowded into the background the one tangible cancer agency which we have to offer the public many ly tumor clinics. The survey should be carried out also to determine where additional tumor clinics might be established. There are too few existing at present, and with careful con-sideration of geographic, as well as population distribution the people of the State may be better served

The funds for this survey might be appropriated by the New York State Division of the American Cancer Society and perhaps it could be conducted under this agency

The Committee is impressed that this is an important matter and would ask the Council to look with favor upon it In the event it is approved your committee would gladly work out the details of its execution

Delection Centers

The Committee discussed at great length the subject of detection centers. It was felt that propagands of one kind or another had ad vanced this reasonably new form of examination to such a point that the public had become conscious of its necessity Realising that all efforts in the past to encourage periodic health examinations had not been entirely successful your committee suggests that a detection center type of examina tion with a definite goal in view for the patient, might stimulate people to greater effort patients seen in detection centers 1 to 2 per cent are found to have pro-cancerous or cancerous lesions while over 30 per cent of patients with other conditions needing treatment are found The by product of the cancer examination is important

"Your committee is of the opinion that detection centers should be encouraged throughout the State To obviate certain unfavorable features of these centers, as now established the Committee

has the following comments to make

Criticism has been leveled at the long waiting lists of established clinics, in some instances appointments being made twelve months in ad-vance. This was felt to defeat the purpose of the examination To overcome this defect it is recom mended that no waiting list be established beyond a reasonable period for the functioning of the center perhaps 4 to 6 weeks Each applicant after that period should then be sent by the center to his own physician or to one of a group of physicians who signify a willingness to conduct this type of examination

In order to have the examinations uniform and complete the physician shall be furnished with a form exactly the same as used by the center When he has finished this examination and completed the form returning a copy to the center he shall be paid a fee set by the center

By such a plan patients will be taken care of promptly and in greater numbers and physicians in the community will participate in the program

A statement on cancer detection centers has been drawn up by your committee, a copy of which is attached hereto

Dr Anderton then interrupted the report to read the statement, as follows

Statement on Cancer Detection Centers

"The organised medical profession has played a leading part in stimulating and guiding the greatly increased interest and activity in cancer control which has occurred within rocent years The confidence thus placed in the profession by the public carries with it a corresponding responsi bility to support any procedure in cancer control which offers even a modest chance of success Cancer detection or case findings by the thorough periodic examination of apparently healthy per sons is such a procedure—Your Cancer Com mittee has studied the principles and methods of cancer detection as developed in various centure now in operation. After thorough consideration of the various implications of this type of examina-tion the Committee endorses the principle of cancer detection or case finding as carried out in cancer detection centers and recommends active support of such centers by the medical profession It should be emphasized that comparable exami-nations may be performed by physicians in their own offices provided arrangements are made to

secure laboratory and x-ray examinations which should be included or which may be indicated Since experience indicates that the presence of organized detection centers stimulates the demand for periodic health examinations by private physicians in their own offices, it is important that physicians review their concepts as to the content of such examinations and make the necessary arrangements to furnish their private patients as complete and thorough an examination as is desırable

"Because there is considerable misapprehension regarding the nature and functions of detection centers, it seems desirable to review the subject

here

"Definition A cancer detection center is an organized medical group for the purpose of providing thorough examinations to apparently healthy adults Although the detection of Although the detection of asymptomatic cancer or of conditions (so-called pre-cancerous) which denote increased risk of developing cancer is the primary purpose of the examination, obviously many other unsuspected health defects may be uncovered by such examinations

"The center does not prescribe or perform any

treatment

"Relation to private practice Persons examined at the center are required to name a private practitioner to whom significant positive findings are to be reported and with whom any indicated therapy is to be discussed by the patient. This does not preclude a general report to the patient by a

physician at the center
"All interested physicians in the community should be privileged to visit the center and, if possible, to participate in its operation on a

rotating schedule

"Personnel of Center The following is a sug-

gested type of organization for the center "Medical internist, gynecologist, general surgeon, otolaryngologist, nurses (3), techniciantechnician-laboratory, secretary, and v-ray. social worker

"One physician should be designated as center chief, either on a permanent or rotating basis

"Other specialists should be on call for special problems which may arise In many centers the functions of the gynecologist may be taken over

by the general surgeon

"A radiologist should be a permanent member of the staff if the examination offered includes fluoroscopic examination of the esophagus and stomach and other x-ray studies of the gastrointestinal tract If the x-ray examination offered is confined to a chest x-ray, an x-ray technician will be needed to take the plates, which may be read outside the regular hours of the center's

"Scope of Examinations The scope of examination offered varies greatly Each center must determine how extensive an examination it can best perform The following procedures may be con-

sidered essential

A thorough history

Physical examination, including examination of the breasts, pelvic examination and rectal examination

Chest 1-ray

"4 Urmalysis, including examination for sugar

Blood serologic test

Vaginal smear examination in women, if this service is available

"Additional procedures, such as fluoroscopic examination of the esophagus and stomach, sigmoidoscopic examination, x-ray examination of the colon should be added if possible, in the order given

"Expected Results of Cancer Detection examination of apparently well persons may be expected to disclose the following types of con ditions (a) pre-cancerous conditions, (b) asymptomatic cancer, (c) other health defects number of such conditions discovered will depend on many factors, including (a) the extent of the examination, (b) the age and sex of the person examined, (c) the extent to which persons having definite clinical symptoms are admitted to the The experience of detection centers indi cates that approximately 4 cancer cases per 1,000 persons examined are discovered The American College of Surgeons has estimated that precancerous conditions are found in 1 5 per cent and other conditions in 30 per cent of those examined It is of interest that a recent survey in Oxford, Mass, revealed unsuspected diabetes in 2 per cent of all persons aged thirty-five years and over

"Importance of Avoiding a False Sense of Security Unless specifically warned, persons who are examined and found not to have detectable cancer may interpret this as meaning they cannot develop the disease for a considerable period after It is important that the lay the examination person be instructed that no such assurance can be given Otherwise symptoms which may develop in the interval before the next examination will be neglected, thereby defeating the very purpose of the examination, which is early diagnosis

"Need for Periodic Re-Examination In order to be effective in helping control cancer, the examination should be repeated every six months if possible The success of detection centers in having their 'patients' return periodically remains problematic It is highly probable that an im portant function of the practicing physician will

be to furnish such re-examinations

"Delay in Obtaining Examination Because of the considerable demand for this type of examina tion, most centers in operation must postpone It should be appointment for several months stressed that in some cases the person asking for an examination already has symptoms all persons who are given an appointment should be warned that if they have any symptoms they should not wait to be examined at the center but should at once consult their own physician Persons with clinical symptoms should not be admitted to the center "

Continuing with the Subcommittee's report "Your committee recommends that the Council encourage the formation of detection centers in the State of New York and that the Cancer Com mittee of each county society be advised of this action. Further, if the Council approves this recommendation, that a suitable editorial be published in the NEW YORK STATE JOURNAL OF MEDICINE, along with the statement of cancer detection centers

"Short Term Courses "The committee discussed the matter of short term courses as outlined by Dr Levin In brief, any physician associated with a tumor clinic or detection center may avail himself of the opportunity to study, for a period of 8-12 weeks, any subject which will help to perfect him in cancer work—ie, pathology, roentgenology, radiation therapy, cellular pathology

Tunds are available by federal grant for this purpose, in sufficient amount to reimburse the physician for tuition and living expenses for the

duration of the course

"It was the feeling of the committee that this project should be encouraged and made known to all physicians in the State having a direct interest in cancer Each county society should be in formed of the plan and any applicant should be recommended through his county society Applications to be made through the committee or

It was roted that the above recommendations be approved and sent to the County Medical So-

rietles.

BCG Advisory Committee -A meeting of the Council Committee on Public Health and Education and the BCG Advisory Committee was held on October 21 1947 Also in attendance were several officers of the Medical Society of the State of New York and representatives of the New York State Department of Health The BCG vaccination program consisting of two parts (1) administrative aspects, (2) technical guide for physicians was presented to the Council for its approval

After discussion at was roted to approve the report

as presented

Public Relations.-Dr Floyd S Winslow chair

man submitted the following report

The New 1 orl. Herald Tribune a magazine section. This Week ' for October 26, contained a splendid discussion of animal experimentation under the title 'Vivisection Lifesaver or Fraud? Much of the material for this article was gleaned from the pamphlet 'Dogs, Drugs and Doctors, prepared by the Public Relations Bureau and supplied to the author of this article

The Lehigh County Medical Society, Allentown, Pennsylvania, has ordered and paid for 1 000 copies of 'Check and Double Check. Approximately

6 000 of these pamphlets remain in stock.

Mr Walsh attended the Sixth District Branch meeting at Norwich, October 15 and the Third District Branch meeting, October 16 at Liberty He and Mr Anderson attended the Fourth Second, and First District Branch meetings at Amsterdam, October 23 Garden City October 29 and Kings-bridge Hospital Bronx, October 30

Mr Anderson and Mr Walsh attended the

Secretaries' meeting at Albany, November 5 Mr Anderson and Mr Walsh attended the annual meeting of Secretaries and Editors at Chicago November

6 and 7

Publication.—Dr George W Kosmak reported that he and Dr Laurance D Redway had attended the Conference of State Medical Association Editors held in Chicago In addition Dr Anderton Mr Auderson, and Mr Walsh were present.

The Publication Committee held its regular meet ug November 12 An editorial based on an ad dition to the Principles of Professional Conduct as toted by the House of Delegates at the 1947 meet ing regarding advertising was discussed matter relates to holding authors responsible more or less for any advertising or other publicity in con nection with publications, articles, or books written for the laity

It was roted that the editorial be withheld and that the Council be requested to submit to the House of Dalegates the question of the advisability of continuing this part of the Principles of Professional Conduct.

The advertising policies of the Journal were dis-

CHARALL

Rural Medical Service - Dr Mellen chairman reported that the committee has answered a questionnaire from Dr Crocker chairman of the Rural Medicine Committee of the A.M.A

with Veterans Administration.-Dr Bauckus chairman, reported that a meeting had been held in Chicago on November 6, under the auspices of the Council on Medical Service of the A.M.A. and the special Veterans Committee appointed by the Trustees of which he was chairman There were about 100 people present, representing 35 states General Hawley spoke for about an hour and was questioned about an hour He made a good presentation and also a good defense, but stated that there were many things beyond his control in the Veterans Administration program. The budget for 1948 of the Veterans Administration is seven billion It is estimated that there are 18,000 000 veterans entitled to or receiving some type of recognition, and that there will be 20,000 000 veterans finally The idea expressed was that the program for those needing medical care will have to be augmented in 1948 and 1949 and reach its height That is one answer to our statement about 1950 that we should discontinue the enlarging of our present facilities Under the present policy only sorvice-connected conditions are cutrified to this 'free choice of physician care

Dr. Hawley stated that Veterans Administration is forced to maintain outpatient clinics to take care of the existing case load, and also because the clinic facilities existed, they were supposed to make use of them but he knew that they did not have sufficient personnel, and would not have it for some years to take care of all of these cases He said there was no intention to expand the facilities, but there was a great deal of work to be done and that the load is expanding He said that probably from July 1946, to July 1947, 780 000 voterans were treated and he thought that in 1949 more than 2 000 000 voterans would receive treatment. Then he said maybe we should treat them all by the private physician plan but there is one fly in the ointment and that is it costs three times as much to do it that way than to do it by the regular facilities of the Veterans Administration Many challenged that and we were promised a breakdown of the figures Of course among the considerations of that was the fact that the veterans anyway go to their private physicians Many of them would not go to the regular facility of the Veterans Administration therefore the load there would be lessened in that

We agreed to meet with the Veterans Administra tion in Washington after our Committee has di gested some of this work

In New York State Dr Butler has recently been appointed Director and Dr. Bauckus is to meet him and take up several problems

Woman's Auxiliary - Dr Beekman chairman re-

ported as follows

The Woman's Auraliary to the Medical Society of the State of New York has been most active in its endeavors to assist the doctors in combating their opponents in the fields of socialized medicine in public relations, and legislation

On September 0 a meeting of the Advisory Council of the Society and the officers, directors, councilors, and chairmen of the standing committees of the Woman's Auxiliary was held at the Hotel Barelay in New York. The president of the Woman's Auxiliary, Mrs. Harry F. Pohlmann, presided. Dr. Dickson and your chairman attended. After the introduction of the council members, your chairman

acknowledged the debt of gratitude the Society owes The president then asked the comthe Auxiliary mittee chairman for suggestions and recommendations as to what should comprise the principle

activities of the fall program of the Auxiliary
The president, Mrs Pollmann, also attended a
majority of the District Branch meetings and gave a very adequate report on the activities of the Auxiliary in a talk before the members of the Second District Branch On October 22 your chairman met with Mrs Pohlmann and received a verbal report of the Auxiliary's activities and learned that these activities have taken her on many journeys throughout the State and even as far as Pennsyl-

On October 7 and 8 the Executive Board of the Auxiliary held its fall meeting at Port Jervis meeting was attended by 20 auxiliary presidents, 30 presidents-elect and 30 officers and chairmen of standing committees The principal speaker at the dinner session was Mr Lee B Mailler, president of the New York State Hospital Association and majority leader in the New York State Assembly At the morning session our field representative, Mr Walsh, spoke on the part each member of the Auxiliary could play in promoting doctor participation in the voluntary medical care plans

The president-elect of the State Auxiliary, Mrs Edgar M Neptune, has also been busy visiting the various counties and is using all her energies to organize auxiliaries in nonparticipating counties and to increase the membership in existing county

auxiliaries

Over 3,000 copies of the first issue of the Auxiliary's publication, the Distaff, were distributed in July through the efforts of Mrs Lec R Sauborn, the editor That this publication was well-received is amply proved by the testimonials of such people as Mrs Luthur H Kice, president-clect of the Woman's Auxiliary to the American Medical Association

Reports have already been received indicating that 28 counties have conducted 33 meetings various county officers and chairmen have made special efforts to interest the different counties in

their individual projects

The untimely death of Dr Alfred L Madden, the husband of our Auxiliary's past-president, has shed a mist of sadness over the members of the Auxiliary and your chairman takes this occasion to express the Council's sympathy in these moments of bereavement to one of the Auxiliary's most zealous members

Your committee is of the opinion that the Auxiliary has proved itself a most helpful adjunct in the field of public relations, and provided that we can furnish it with the guidance it so ardently seeks, the Auxiliary will be most helpful to us in our efforts to improve the quality and quantity of medical care and in helping the public to understand our views on socialized medicine, voluntary medical care plans and legislation in so far as it affects the health of our people

Workmen's Compensation —Dr J Stanley Ken-

ney, chairman, presented the following report
Radiology On October 7, 1947, the special
examining committee on Radiology examined five candidates

Meetings On October 25 your director attended a meeting of the special committee of the Connecticut State Medical Society to consider a revision of the Workmen's Compensation Law of the State of Connecticut, and on November 5 he attended a meeting of the Secretaries held in Albany

Medical Practice Committee It has been called to our attention by a member of the Council that the

Eric County Medical Society, over which the Medical Practice Committee has no jurisdiction, continues to receive communications signed by that Committee in reference to Workmen's Compensation matters The Eric County Medical Society has on a number of occasions complained about the alleged attempts on the part of the Medical Practice Committee to assume jurisdiction outside of counties having a population of one million or more The matter is again brought to the attention of the Council

It has been reported by four of the County Societies in New York City that, although the Medical Practice Committee is requesting the societies to pass upon the qualification of physicians in the first instance based upon their applications for original or re-rating, the Medical Practice Committee is not following their recommendations in many in

State Employed Physicians We have reported to the Council on one or more occasions that the Work men's Compensation Board has refused to authorize ecrtain physicians recommended by county medical societies for authorization, who are in the employ of the State of New York We are in receipt of a letter from Dr Gerald E Murphy, Mt Morris, New York, chairman of the Compensation Committee of the Medical Society of the County of Livingston, to the effect that a physican at Peterson Hospital, Sonyea attends many compensation cases arising out of con struction work on the hospital grounds, and this physician has been refused authorization by the The County Workmen's Compensation Board Society Committee is in favor of granting a rating It is the opinion of Dr Murphy that certain com pensation cases cannot be cared for properly unless this physician has a rating under the Workmen's Compensation Law A rating to this physician was refused over a year ago. We have been requested by Dr Murphy to refer this matter again to the Workmen's Compensation Board This is a matter of great importance and steps should be taken to obtain the cooperation of the chairman of the Work men's Compensation Board in this matter, so that proper medical care may be given to claimants in certain rural sections of the State

Legislation for introduction at the Legislation1948 Session of the Legislature has been prepared and

submitted to the Legislative Committee
The Chairman of the Workmen's Compensation
Board has requested the New York State Journal OF MEDICINE to publish a paper read by her before the Saranac Symposium on October 3, 1947, on "Viewpoints of Workmen's Compensation Adminis tration as to Occupational Diseases" Owing to the lack of space, it was impossible to publish the paper in full, but an abstract was made at the request of the editor and was published in the December 1 issue

### New Business

Dr Anderton reported that the American Medical Association will hold its Eighth Annual Congress on Industrial Health in Cleveland, Ohio, on January and 6, 1948, and has requested that this Society send a representative or representatives Dr Mitchell, under whose Committee on Public Health and Edu ention there is a Subcommittee on Industrial Health has taken the liberty to suggest that the expenses of going to that meeting be defrayed for Dr Leon Griggs, of Syracuse, who is the Chairman of his Subcommittee on Industrial Health

It was voted that the Council recommend to the Board of Trustics that Dr Griggs expenses

be paid

### NECROLOGY

Lynn Staley Beals M.D of Buffalo, died on October 2 at the age of seventy After being gradu aled in 1901 from the Harvard Medical School, Dr Beals interned at the Massachusetts General Hospital in Boston. He was attending physician at lafayette General and the Salvation Army hospitals in Buffalo and assistant professor of medicine at the University of Buffalo School of Medicine prior to his retirement nine years ago. Dr. Beals was a member of the Medical Union of which he is a past officer, the Roswell Park Medical Club the Ameri can Medical Association and the Eric County and New York State medical societies

Gernt F Blauvelt, M D of Nyack oldest alumnus of City College, New York City and dean of Rockland County physicians and surgeons died on November 12 at the age of ninety-eight lerectived his medical degree from the College of Physicians and Surgeons Collegible University in 1972 and and Surgeons Columbia University in 1873 and served as an intern at Roosevelt Hospital in 1873 and 1874. He later studied at the University of Stra bourg for two years specializing in surgery and upon his return became resident surgeon at New York Hospital On January 1 1900, Dr Blauvelt performed the first operation in Nyack Hospital of which he was a founder He was a member of the Rockland County and New York State medical societies and the American Medical Association

William Turner Carstarphen M D of New York City died on November 2. He was seventy two years old. He was graduated fom Jefferson Medi cal College Philadelphia in 1901 and after practicing medicine in Garysburg North Carolina joined the medical faculty of Wake Forest College in North

Carolina

During World War I Dr Carstarphen was a colonel in the Army Medical Corps serving as special instructor at Camp Pike Arkansus sanitara inspector of the 87th Division in England and post surgeon at the Foreign Office in Paris In World surgeon at the Foreign Office in Paris In World War II Dr Carstarphen was appointed by the War Rail Dr. Carstarphien was appointed by the rail Relocation Authority as chief medical officer at the Japanese-American Camp at Rohwer Arkanese and later held the same post at Granada Colorado Clarence O Cheney, M.D. of White Plains retired medical director of the Westchester Division of New York Housits! Med Samedor 4. He was

New York Hospital died November 4 He was sixty years of age. He was graduated from the College of Physicians and Surgeons in 1911 and began his medical career at the Manhattan State Hospital Wards Island From 1917 to 1922 he was assistant director of the New York State Psychiatric Institute Wards Island Later Dr Chency was pital medical superintendent of the Hudson River State Hospital, Poughkeopsle medical director of the New York State Psychiatric Institute and Hospital Conternation of the New York State Psychiatric Institute and Hospital Conternation of the New York State Psychiatric Institute and Institute Conternation of the New York State Psychiatric Institute Conternation of the New York State Psychiatric Contents of the New Y the New York State Psychiatric Institution Country Inspiral Columbia Presbyterian Medical Center, May York City and professor of psychiatry and how York City and professor at the College elecutive officer of the department at the College of I hysicians and Surgeons

Dr Cheney was professor of clinical psychiatry Dr. Gieney was professor of climcal psychiatry at Cornell University Medical College for six years until his rothrement in 1940. He was consultant psychiatras to he New York Hospital Bellevue Hospital, White Plains Hospital Grasslands Hospital in Valhalla 5t. Luke & Hospital New York City Vassar Brothers Hospital in Poughkeepsic and the Northern Westchester Hospital Mount

During World War I he was a member of the New York City draft board and in World War II he was psychiatrist to the medical advisory board of Westchester County He was also consultant in psychiatry to the Veterans Administration and was awarded the Congressional Selective Service Medal

Dr Cheney was associate editor of the American Journal of Psychiatry and the Psychiatric Quarterly He was a member of the American Psychiatric Association the Association for Research for Nervous and Mental Diseases the New York Academy of Medicine the New York Clinical Psychiatric Society the New York Neurological Society and the New York Psychiatric Society He was a past president of the Dutchess County Medical Society and a member of the American Medical Association and the State Medical Society
Raffaele Crescitelli M.D of the Bronx died on

November 11 He was seventy-six years of age Dr Crescitelli received his medical degree from the

University of Naples in 1897

Albert Nelson Crouch M D of Schenectady dred on September 24 at the age of sixty-seven graduate of Albany Medical College in 1915 he practiced medicine in Schenectady for the past thirty four years For sexteen years Dr Crouch was consulting radiologist at Ellis Hospital, opening his own x ray office in 1938 He was medical head of the American Locomotive Company for thirty Dr Crouch was a member of the American Medical Association the Schenectady County and New York State medical societies the Radiology Society of North America and the New York State Society of Internal Medicine

Jules Jehin de Prume, M.D. of New York City died on November 11 He was seventy seven years old An eye car nose and throat specialist, Dr do Prume had practiced in New York since 1902 He received his medical degree from the University of Paris in 1893 and studied and practiced in Eng land before coming to the United States He was associated with Misericordia Hospital, New York

Martin John Beheverris M.D., physician in-chief of the \cw \ork Dispensary since 1923 died on \circ veinber 5. He was eighty three years old. He was graduated from Columbia University College was graduated from Common University Consequence of Physicians and Surgeons, in 1889 becoming a member of the New York Disponsary's staff more than fifty years ago. Dr. Echeverria was a member of the New York County and State medical societies the American Unological Association and the American Unological Association and the American Unological Securities. ean Medical Association

Isidor Ginzburg M D of New York City died in November He was seventy five years old and was graduated from Cornell University Medical College in 1900 Dr Ginzburg was the author of several

books on Talmudic subjects

Max Hühner M D., of New York City died on November 8 at the age of seventy-four Aurologist Dr Huhner devised the Hühner test for sterility He received his medical degree from Columbia University College of Physicians and Surgeons in 1893 and interned at Bellevue Hospital where he later became attending genitourinary surgeon. For a time he was chief of the clinical genitourinary department of Mount Sinai Hospital. Dr Huhner was a fellow of the American Vedical Association the American Urological Association and the New York Academy of Medicine He was a diplomate of the American Board of Urology and a member of the New York County and State medical societies, the New York Urological Association, and the Society He was the author of of Medical Jurisprudence several books on sterility

Charles James Mooney, M D, of New York City and New Rochelle, died on November 6 He was eighty-four years old A specialist in arthritis, Dr Mooney was graduated from New York University

Medical School in 1889

William Frederick Neumann, M D , of New York City, died on May 17 He was seventy-six years of Dr Neumann was graduated from Columbia University, College of Physicians and Surgeons, in

William Giles Phipps, M D, sixty-one, died on November 2 at his home in Mount Vernon attended Cornell University Medical College and was graduated from the College of Physicians and Surgeons, Columbia University, in 1913 During World War I he served in the Army Medical Corps Dr Phipps was a member of the Mount Vernon Medical Association and the Westchester County Medical Society

Samuel W Rock, M D, of New York City, died on October 16 He was fifty-four years old A graduate of New York University and Bellevue Medical College in 1915, Dr. Rock was associate surgeon and chief of the outpatient department of Beth Israel Hospital in New York City fellow of the American College of Surgcons and a member of the New York State and County medical societies and the American Medical Association

Ervin Torok, M.D., seventy, died on November 6 at his home in New York City — An ophthalmologist who had practiced in New York for forty years, Dr. Torok had been professor of ophthalmology at the New York Polyclinic Medical School and Hospital for the last fifteen years He was graduated from

the University of Budapest Medical School in 1899. came to the United States in 1906, and received his license to practice in New York State the following year Until his resignation in 1938, Dr Torok was chief of the eye department of Beth Israel Hospital for more than twenty-five years He was associated also with the Beckman-Downtown Hospital, New York City, the Tarry town Hospital Grasslands Hospital, Valhalla, and the Ossining Hospital

Dr Torok was a member of the American Ophthalmological Society, the American Medical Association, the American Medical Authors Association, and the New York County and State medical socie-He was the author of Handbool of Surgery

and had published papers on eye surgery

Earl Edward Van Derwerker, M D, of New York City and Newtown, Connecticut, died on November 2 at the age of fifty-five Former attending orthopedic surgeon at the Hospital for Special Surgery, New York City, Dr Van Derwerker retired from private practice in 1939 He obtained his medical degree from the College of Physicians and Surgeons, Columbia University, in 1917 He was attending surgeon at Blythedale Home, Hawthorne, for seventeen years, orthopedic surgeon at Lawrence Hospital, Bronxville, and consulting orthopedic surgeon at St Luke's Hospital, Newburgh, and Eastern New York Orthopedic Hospital, Schenectady diplomate of the American Board of Orthopedic Surgeons and a fellow of the American College of Surgeons

Carlos Green Webster, M D, of the Brons, died A graduate October 30 at the age of seventy-five of the Cleveland Medical School in 1896 and the New York Homeopathic College in 1904, Dr Webster practiced medicine for forty-three years in the Bedford Park section of the Brony He was formerly on the staff of the Flower and Fifth Avenue Hospital, New York City He was consultant to the Consolidated Gas Company on gas poisoning

### NAIL REMOVED FROM SMALL INTESTINE BY MAGNET FOR FIRST TIME

For the first time a foreign body has been removed from the duodenum (the part of the small intestine leading from the stomach) by a magnet, according to an article in the October 18 issue of The Journal of the American Medical Association

Up to this time a serious surgical operation has always been necessary, say the writers, Murdock Equen, M D, Robert Gilliam, M D, and Merrill Lineback, M D, all associated with the Ponce de Leon Ear, Nose and Throat Infirmary of Atlanta,

Georgia

The case involved a four-year-old boy who had swallowed a nail, which reached the second portion of his duodenum, point up, two days later. An operation was planned. Then someone suggested that perhaps the nail could be removed by means of the magnet which has so greatly simplified the removal of safety pins from the windpipe and the

removal of any magnetic foreign body from the stomach. The boy was brought to the Ponce de

Leon Infirmary

With the help of a "chocolate malted" the child finally succeeded in swallowing a new model of the magnet, slightly curved so that it could get around curves more easily, and with a groove around one end holding a loop of strong waxed thread Several hours later he exclaimed that he had "felt something click," and complained of a dull pain showed the magnet in contact with the nail

The boy was then given other, and under v-ray guidance the magnet and nail were slowly pulled back into the stomach by the string All three The procedure could then be rapidly withdrawn took less than two minutes, the doctors report, and by the next day the boy was none the worse for his

experience